

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02564

## CERTIFICATE OF DEATH

02550

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3801-4 Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>II months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Nursing Home</u>		d. STREET ADDRESS <u>1738 E. 30th Street</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mr. Joseph H. Alban</u>		4. DATE OF DEATH <u>March 3rd</u> 19 <u>57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 1, 1885</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>9</u> Days <u>2</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman, Novelty</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George H. Alban</u>		14. MOTHER'S MAIDEN NAME <u>Ella Mulligan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-16-9141</u>	
17. INFORMANT <u>Miss Annette C. Alban</u>		Address <u>1738 E. 30th St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary congestion</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocarditis chronic with failure</u> DUE TO (c) <u>Myocardial hypertrophy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 years</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Advancing years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.] <u>no injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) <u>none</u> (County) (State)	
21. I certify that I attended the deceased from <u>Dec 10, 1955</u> to <u>Mar 3, 1957</u> , that I last saw the deceased alive on <u>March 3, 1957</u> , and that death occurred at <u>8:25 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James Graham Marston</u> M.D.		ADDRESS (Street, city or town, state) <u>516 Cathedral Street Balto Md</u>	
PHYSICIAN'S NAME (Type) <u>James Graham Marston, M.D.</u>		DATE SIGNED <u>3-4-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/6/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR <u>W. H. Smith</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

# STATE OF OHIO DEPARTMENT OF HEALTH

BUREAU V. S.

MAR 6 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02565

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02551

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <b>Williamsville 69X-3</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Western Md. R.R. Nr. Woodholme Ave.</b>				d. STREET ADDRESS <b>5210 Main St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HELEN</b> Middle <b>ALLINA</b> Last <b>ALLINA</b>				4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-6-1900</b>		9. AGE (In years last birthday) <b>56</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Photographer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Photography</b>		11. BIRTHPLACE (State or foreign country) <b>Vienna, Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Herzog</b>				14. MOTHER'S MAIDEN NAME <b>Gisela Neuspiel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>060-22-9555</b>		17. INFORMANT <b>Prof. Fritz Machlup</b> Address <b>312 Church Lane, Pikesville</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Fractures of both arms, both legs,</b> <b>979X</b> DUE TO <b>crushed chest, fractured skull.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Due to being run over by train</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Stepped in front of oncoming train.</b>					
20c. TIME OF INJURY Month, Day, Year <b>5</b> Hour <b>9:00</b> P.M. <b>3-1-57</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>R.R. tracks</b>		20f. (City or town) (County) (State) <b>Pikesville, Balto., Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>D. D. Caples</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REBURYAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>3-2-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Crematorium</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell, Pikesville</b>				24a. REC'D BY REGISTRAR <b>MAR 4 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Anthony Newell</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

MAR 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02566

CERTIFICATE OF DEATH

02552

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>3 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>House in the Pines Catonsville</u>				d. STREET ADDRESS <u>3234 Belair Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> (Wife) Last <u>M. Armstrong</u>				4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 7 - 1899</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Weaver</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Nagengass</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215050749</u>		17. INFORMANT <u>George Earl Armstrong</u> Address <u>3234 Belair Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lympho. sarcoma</u> <u>200.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized metastases</u> DUE TO (c) <u>5 yrs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct</u> 19 <u>56</u> , to <u>March 14, 1957</u> , that I last saw the deceased alive on <u>March 10, 1957</u> , and that death occurred at <u>A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. Bernard J. Cohen</u> M.D.				DATE SIGNED <u>the Mary Carter apt</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>Belair Rd Balto. 6 Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Reginald B...</u>				ADDRESS <u>7110 Belair Rd</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 18 57</u>	
24b. REGISTRAR'S SIGNATURE <u>Reginald B...</u>							

# CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

DATE OF DEATH

BUREAU V. 3

MAR 18 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02567 CERTIFICATE OF DEATH

Reg. Dist. No.

02553

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 14</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 14</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1731 Wycliffe Avenue</b>				d. STREET ADDRESS <b>1731 Wycliffe Ave</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Jane</b>		First <b>C.</b> Middle <b>Atkinson</b> Last		4. DATE OF DEATH Month <b>March</b> Day <b>16</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 27, 1871</b>		9. AGE (In years last birthday) yrs. <b>85</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William B. Williams</b>				14. MOTHER'S MAIDEN NAME <b>Virginia C. Simonds</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Miss E. Virginia Atkinson, 1731 Wycliffe Road</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> <b>733x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture of both lower R leg</b> DUE TO (c) <b>Osteoporosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b> <b>10 wks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 4</b> 19 <b>57</b> to <b>March 16</b> 19 <b>57</b> that I last saw the deceased alive on <b>3/15</b> 19 <b>57</b> , and that death occurred at <b>7:45 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Coral Gordon</b>				ADDRESS (Street, city or town, state) <b>300 E. North Ave</b>			
PHYSICIAN'S NAME (Type) <b>Coral Gordon M.D.</b>				DATE SIGNED <b>3-18-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-19-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>3/19/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Dr. H. M. Bacon</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. B.

MAR 20 1957

RECEIVED

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02568

## CERTIFICATE OF DEATH

02554

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balt.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>5905 Gwynn Oak Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Elizabeth Boettner Baldwin</b>				4. DATE OF DEATH Month <b>March</b> Day <b>17</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 16, 1875</b>		9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Frostberg, Md.</b>	
13. FATHER'S NAME <b>John Boettner</b>				14. MOTHER'S MAIDEN NAME <b>Anna Kahill</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Frank M. Baldwin 5905 Gwynn Oak Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Atherosclerosis with senility</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>April 3, 1955</b> to <b>March 12, 1957</b> , that I last saw the deceased alive on <b>March 15, 1957</b> , and that death occurred at <b>11:45 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Leon Ashman</b>				DATE SIGNED <b>3-18-57</b>			
PHYSICIAN'S NAME (Type) <b>LEON ASHMAN</b>				ADDRESS (Street, city or town, state) <b>5907 Gwynn Oak Ave. Baltimore 7 Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 20, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc. 1900 Eutaw Place</b>				24a. REC'D BY REGISTRAR <b>MAR 20 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Hm. E. Martin</b>	

AT 2200148—WYANDOTTE TREATMENT PLANT—BETHLEHEM

MAR 20 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

02555

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02555

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finksburg</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>Deer Park Road</b>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Henry</b> Last <b>Balzanna</b>				4. DATE OF DEATH Month <b>March</b> Day <b>31</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 20, 1912</b>		9. AGE (In years last birthday) <b>44</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck driver</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Samuel Balzanna</b>				14. MOTHER'S MAIDEN NAME <b>Annie E. Justice</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>215-05-3319</b>		17. INFORMANT Address <b>Alice A. Balzanna, Finksburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m.		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>D. D. Caples</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>D. D. Caples, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 3, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Memorial Gardens, Finksburg, Md.</b>		22d. LOCATION (City, town, or county) (State) <b>Finksburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>4-1-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary S. Eline</b>	

MEDICAL CERTIFICATION

BUREAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02556

## 02539 CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1813 WALNUT AVE</u>				d. STREET ADDRESS <u>1813 WALNUT AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE B. BECKMAN</u>				4. DATE OF DEATH Month Day Year <u>3-24-1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-15-1881</u>	9. AGE (In years last birthday) <u>76</u> yrs	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERICAL</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OFFICE</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>							
13. FATHER'S NAME <u>UNK</u>				14. MOTHER'S MAIDEN NAME <u>UNK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNK</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-01-2479</u>			
17. INFORMANT <u>Mr Phelps</u> Address <u>1813 Walnut Ave Balto 22</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>secondary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>infectious</u> DUE TO (c) <u>unknown</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UNK</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>UNK</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>UNK</u>	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>October 15, 1956</u> , to <u>March 24, 1957</u> , that I last saw the deceased alive on <u>March 20, 1957</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>D. H. Thomas</u> M.D. <u>107 N. Main St Balto 22</u>				DATE SIGNED <u>3/29/57</u>			
PHYSICIAN'S NAME (Type) <u>D. H. Thomas</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-1-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Acacia Hill of Jones</u>		22d. LOCATION (City, town, or county) (State) <u>Balto, Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brock Boddy, Dundalk, MD</u> ADDRESS <u>UNK</u>				24a. REC'D BY REGISTRAR <u>APR 1 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>	

BUREAU V. S.

APR 2 1977

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may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
02570 Item 12 primary 12 3-20-57 et  
CERTIFICATE OF DEATH

02557  
32

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>				c. LENGTH OF STAY IN 1b <b>11 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				e. STREET ADDRESS <b>623 S. BOND STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>STANISLAW</b> Middle <b>BENICEWICZ</b> Last <b>BENICEWICZ</b>				4. DATE OF DEATH Month <b>3</b> Day <b>18</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-2-1896</b>	
9. AGE (In years last birthday) <b>60</b> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>TAILORING</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>IGNATIUS BENICEWICZ</b>				14. MOTHER'S MAIDEN NAME <b>PHYLLIS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT Address <b>Hospital records, Mt. Wilson State Hospital</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROSIS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULMONARY TUBERCULOSIS</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>10 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-17-1956</b> , to <b>3-18-1957</b> , that I last saw the deceased alive on <b>3-17-1957</b> , and that death occurred at <b>3:40 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>3-18-57</b>							
ACTUAL SIGNATURE <b>William Newsum</b> M.D.							
PHYSICIAN'S NAME (Type) <b>William Newsum, M.D., Supt.</b>				Mt. Wilson State Hospital, Mt. Wilson, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>March 20, 1957</b>		<b>St. Stanislaus</b>		<b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Fred W. Ozajewski 1930 Eastern Ave</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 21 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dorothy Newell</b>	

RECEIVED

MAR 1 1957

BURMAN & L

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02558

02571

## CERTIFICATE OF DEATH

Reg. Dist. No. 38 26

1. PLACE OF DEATH- COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland		COUNTY Carroll	
CITY (If outside corporate limits, write RURAL and give nearest town) Towson		LENGTH OF STAY On this place 1 month		CITY (If outside corporate limits, write RURAL and give nearest town) Westminster			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Towson Convalescent Home				STREET ADDRESS 31 Ridge Road		(If rural, give location)	
3. NAME OF DECEASED (Type or Print) HAZEL		(First) K. Ruth		(Last) BENNIGHOF		DATE OF DEATH MAR 19 1957	
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Dec. 17, 1891	
				9. AGE last birthday 65 yrs.		If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Co. School		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME John Shearer				14. MOTHER'S MAIDEN NAME Nancy Jane Hough			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-20-3470		17. INFORMANT AND ADDRESS C. L. Bennighof Westminster, Md.			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)---

BRONCHOPNEUMONIA

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)---

CEREBRAL VASCULAR ACCIDENT

(c)---

CEREBRAL ARTERIOSCLEROSIS

INTERVAL BETWEEN  
ONSET AND DEATH

12 HOURS

6 WEEKS

YEARS

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURY m.INJURY OCCURRED  
While at Not While  
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAR 19, 1957 to , 19 , that I last saw the deceased

alive on MAR 19, 1957 and that death occurred at 2:15 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION  
REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL  
REG.

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

MAR 20 1957

Harriet A. Miller

John R. Byers Westminster, Md.

Mabel Byers

MARGIN RESERVE FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02540 CERTIFICATE OF DEATH

02559 41

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>1</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<b>Life</b>		<b>53 Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8811 Wise Avenue</b>		d. STREET ADDRESS <b>8811 Wise Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Peter</b> Middle <b>J</b> Last <b>Binco</b>		4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 27, 1911</b>
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Co. Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Binco</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Bacza</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-09-1675</b>	
17. INFORMANT <b>Mrs. Frances Binco</b>		Address <b>8811 Wise Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Transverse Colon</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b> <b>? 1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 15, 1957</b> , to <b>March 10, 1957</b> , that I last saw the deceased alive on <b>March 10, 1957</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. G. Windsor</b>		ADDRESS (Street, city or town, State) DATE SIGNED <b>520 D St. Sp R 13 Md 3-12-57</b>	
PHYSICIAN'S NAME (Type) <b>R. G. WINDSOR</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 14-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>	22d. LOCATION (City, town, or county) (State) <b>Dundalk Ave. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda</b>		ADDRESS <b>2829 Hudson St. 24. Md.</b>	
24a. REC'D BY REGISTRAR <b>MAR 14 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Am. Kelly</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

MAR 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02572

CERTIFICATE OF DEATH

025608

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admision) a. STATE <u>md.</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>468 FAIRMOUNT AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>AGNES</u> Last <u>BISCOE</u>				4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 23, 1871</u>	
9. AGE (In years last birthday) <u>85</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>			
13. FATHER'S NAME <u>LAFAYETTE LANGLEY</u>				14. MOTHER'S MAIDEN NAME <u>MARIE BISCOE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>REGINA NEBLETT</u> Address <u>468 FAIRMOUNT AVE</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>MAR 13, 1957</u> to <u>MAR 19, 1957</u> , that I last saw the deceased alive on <u>MAR 13, 1957</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>T. P. SIWINSKI</u>				ADDRESS (Street, city or town, state) <u>17 W. PENNA. AVE TOWSON</u> DATE SIGNED <u>3/20/57</u>			
PHYSICIAN'S NAME (Type) <u>T. C. SIWINSKI</u>				M.D. <u>MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. PETERS</u>		22d. LOCATION (City, town, or county) (State) <u>RIDGE, ST. MARY'S CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tom L. Schatzman</u> ADDRESS <u>1701 McCulloch Baltimore, Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 22 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Hubert Gray</u>	

U.S. A.

1951

RECEIVED

02573

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02561

Items 1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN <b>Baltimore</b> <small>(If outside corporate limits, write RURAL and give nearest town)</small>				c. CITY OR TOWN <b>Catonville</b> <small>(If outside corporate limits, write RURAL and give nearest town)</small>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>108 Locust Drive</b>				e. STREET ADDRESS <b>108 Locust Drive</b> <small>• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></small>			
3. NAME OF DECEASED (Type or print) <b>Alice</b> First <b>A</b> Middle <b>Bloodsworth</b> Last				4. DATE OF DEATH <b>Month</b> <b>Day</b> <b>Year</b> <b>Mar. 9, 1957</b> <b>19</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 30, 1889</b>	9. AGE (In years last birthday) <b>67</b> yrs.	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>April 20 1889 Md USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Aaron</b>				14. MOTHER'S MAIDEN NAME <b>Alice Braun</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular Disease</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Geo. S. M. Kieffer</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Geo. S. M. Kieffer</b> M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>March 9, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3-17-57</b>	22c. NAME OF CEMETERY OR CREMATOR <b>New York</b>	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Cook</b>			ADDRESS <b>1217 St Paul St</b>	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <b>Geo. S. M. Kieffer</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAR 13 1907

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02574 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02562

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Katie Estelle Balto.</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>Catonsville</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>437 Whitfield Ave.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u> Md. </u> b. COUNTY <u> Balto. </u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>437 Whitfield Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Katie Estelle Boone</u>				<b>4. DATE OF DEATH</b> Month <u> Mch. </u> Day <u> 13. </u> Year <u> 1957 </u>			
<b>5. SEX</b> <u>Fem</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>Feb. 24, 1881</u>		<b>9. AGE</b> (In years last birthday) <u>76</u>		<b>10. IF UNDER 1 YEAR</b> Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House wife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>			
<b>11. BIRTHPLACE</b> (State or foreign country) <u> Md. </u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u> U S A </u>			
<b>13. FATHER'S NAME</b> <u>Alec Anderson</u>				<b>14. MOTHER'S MARRIED NAME</b> <u>Laura Yeakel</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u> </u>			
<b>17. INFORMANT</b> <u>Mr. Roland A. Boone</u>				<b>Address</b> <u>437 Whitfield Ave.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <u>422.1</u> <b>IMMEDIATE CAUSE (a)</b> <u>Cerebral Accident</u> <b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b> <u>Cardio vascular disease</u> <b>DUE TO</b> <b>(c)</b> <u> </u>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>					
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> 19 </u>		<b>20d. INJURY OCCURRED</b> White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u> </u>			
<b>20f. (City or town)</b> <u> </u>		<b>(County)</b> <u> </u>		<b>(State)</b> <u> </u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>SIGNATURE</b> <u>Geo. S. M. Kieffer</u>				<b>DATE SIGNED</b> <u>Mch. 13, 1957</u>			
<b>EXAMINER'S NAME (Type)</b> <u>Geo. S. M. Kieffer M. D.</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>3-16-57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Western Cem.</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>Baltimore</u>		<b>(State)</b> <u> Md. </u>		<b>24a. REC'D BY REGISTRAR</b> <u> </u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. J. Tickner &amp; Sons</u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u> </u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MAR. 18 1977

BUREAU V. S.

02575

## CERTIFICATE OF DEATH

02563

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>19yr3mth22dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SIDING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>	
f. STREET ADDRESS <b>Brandywine, Maryland</b>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>Loretta</b> Last <b>Johnson Bowers</b>		4. DATE OF DEATH Month <b>3</b> Day <b>5</b> Year <b>1957</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1884</b>
9. AGE (In years last birthday) <b>72</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Lewis C. Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Isabel Evans</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SIDING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary emboli</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic C. V. D</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Tonsillitis February 1957, Gallstones</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 27, 1957 to 3.5.1957</b> , that I last saw the deceased alive on <b>3.5.1957</b> , and that death occurred at <b>5 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gertrude J. Fleischmann</b> M.D.		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>3.5.57</b>	
PHYSICIAN'S NAME (Type) <b>GERTRUDE J. FLEISCHMANN</b>		Catonsville 28, Maryland	
22a. <del>PREPARED</del> CREMATION, (Specify)		22b. DATE THEREOF <b>3-7-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Land Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>3820 Frederick Gd. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George H. Forley</b>		ADDRESS <b>Catonsville Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 8 57</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be given to the funeral director for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 8 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02564

02576

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Balto. Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>md</i> b. COUNTY <i>Carroll Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ellicott City</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminister</i>	
c. LENGTH OF STAY IN 1b <i>3 WKS.</i>		d. STREET ADDRESS <i>R. F. D.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>28 Westchester Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>PAUL DEWEY BRANDENBURG</i>		4. DATE OF DEATH Month <i>MAR.</i> Day <i>23</i> Year <i>1957</i>	
5. SEX <i>m</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/18/98</i>
9. AGE (In years last birthday) <i>58</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Contractor</i>	
11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Charles Brandenburg</i>		14. MOTHER'S MAIDEN NAME <i>Emma May Rohrbach</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>Lucille Brandenburg</i>	
17. INFORMANT <i>Lucille Brandenburg</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anaplastic carcinoma of lung with metastases</i> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb 14</i> , 19 <i>57</i> , to <i>March 23</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>March 23</i> , 19 <i>57</i> , and that death occurred at <i>7:34 A.</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <i>3/28/57</i> ACTUAL SIGNATURE <i>Dr. H. A. Kochman</i> M.D. _____ PHYSICIAN'S NAME (Type) <i>Dr. H. A. Kochman</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<i>Burial</i>		<i>3/26/57</i>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>St. John</i>		<i>Ellicott City md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<i>MacArthur Son Catonsville 28</i>		<i>MAR 28 1957</i>	
ADDRESS _____		24b. REGISTRAR'S SIGNATURE	
		<i>Dr. H. A. Kochman</i>	

RECEIVED  
MAR 10 1957  
BUREAU V. S.

# 02577 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02565  
44

Reg. Dist. No.

1. PLACE OF DEATH <del>At Sea</del> <b>At Sea</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>North Carolina</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Richlands</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>(Ship) S. S. Cubor</b>				d. STREET ADDRESS <b>Route #1</b>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>BROOKS</b> Last				4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 2, 1918</b>	9. AGE (In years last birthday) <b>38</b> yrs.	IF UNDER 1 YEAR Months Days Hours M'n.	IF UNDER 24 HRS. Months Days Hours M'n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sparrows Pt. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Onslou Co. N.C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>James M. Brooks</b>				14. MOTHER'S MAIDEN NAME <b>Dolly Diner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-- Yes</b>		16. SOCIAL SECURITY NO. <b>246-20-7155</b>		17. INFORMANT <b>Mrs. Martha Brooks, Route 1, Richland N.C.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Hemothorax</b> <b>5/12</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>Mar. 7th/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Richland N.C.</b>		22d. LOCATION (City, town, or county) (State) <b>N.C. (Richland)</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip Harvey, Sons,</b>				ADDRESS <b>2024 Orleans St. 31</b>		24a. REC'D BY REGISTRAR <b>MAR 11 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Dawson L. Fisk</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please write "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAR 12 1967

RECEIVED

02578

## CERTIFICATE OF DEATH

02566

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>3 Mos.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10 Edmondson Ridge Rd.</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>S.</b> Middle <b>Earl</b> Last <b>Brown, Sr.</b>		4. DATE OF DEATH Month <b>Mich.</b> Day <b>7,</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 9, 1885</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Yardmaster, Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>P. R. R.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Samuel J. Brown</b>		14. MOTHER'S MAIDEN NAME <b>Emily Kirk</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Mrs. Margary Burg</b>		Address <b>10 Edmondson Ridge Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Ca of Cerebrum</b> <b>180x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Transitional Cell Ca of Renal Pelvis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b> <b>1 yr.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1-5</b> , 19 <b>57</b> , to <b>3-7</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3-4</b> , 19 <b>57</b> , and that death occurred at <b>10:50 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6209 Frederick Ave. Baltimore 28, Md.</b> DATE SIGNED <b>3-5-57</b>			
ACTUAL SIGNATURE <b>Wilmer K. Gallagher</b>		M.D. <b>6209 Frederick Ave. Baltimore 28, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mich. 11, 57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Union Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Chester Co. Penna.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Janley Funeral Home</b>		ADDRESS <b>Catonsville, Md.</b>	24a. REC'D BY REGISTRAR <b>3-11-57</b>
		24b. REGISTRAR'S SIGNATURE <b>Rebecca</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 11 1957

RECEIVED

## 02551 CERTIFICATE OF DEATH

Reg. Dist. No.

2. DATE OF DEATH 3/16/57

1. NAME OF DECEASED (Type or Print)

Josephine Bruce

3. PLACE OF DEATH

A. Baltimore City

B. FULL NAME OF (If not in hospital or institution, give street address or location)

136 Oakley Village

c. Length of stay in Baltimore

70

Yrs. Days

5. SEX

Female - white

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

operator

10B. KIND OF BUSINESS OR INDUSTRY

Goldman Co.

13. FATHER'S NAME

Charles A. Byron

15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mr Arthur E. Bruce

ADDRESS

136 Oakley Village

18. 334X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Apoplexy

DUE TO

(B) Sclerosis

DUE TO

(C)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☐

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 1955 to March 16 1957, that (I) (we) last saw the deceased alive on Jan 16 1957, and that death occurred at 4 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Attending Phys. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

23B. ADDRESS

3033 W North A

23C. DATE SIGNED

3/18/57

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/19/57

24C. NAME OF CEMETERY OR CREMATORY

London Park Cem.

24D. LOCATION (City, town, or county)

1801 Frederick Ave

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Dr. Arthur E. Bruce

25. FUNERAL DIRECTOR

John G. Bowman

ADDRESS

99 St.

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information so carefully supplied. Physicians: please write the causes of death clearly and leg. THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER THE DEATH.

RECEIVED

MAR 20 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 1 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02579 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02568

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Howardville</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Howardville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7141 Walnut Ave.</b>				d. STREET ADDRESS <b>7141 Walnut Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WAYMAN JOSEPH BRYANT</b>				4. DATE OF DEATH Month Day Year <b>March 18 19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 15, 1895</b>		9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Owen A. Bryant</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Bell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Grace O. Bryant, 7141 Walnut Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>D. D. Caples</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>3-20-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 21, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas</b>		22d. LOCATION (City, town, or county) (State) <b>Randallstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Holland Funeral Home, 1631 Druid Hill Ave.</b>				24a. REC'D BY REGISTRAR <b>DR 211</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Jm. E. Martens</b>	

BUREAU V. S.

MAR 21 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File Page 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# 02541 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02569

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anna Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale, Glen Burnie P.O.</u> d. STREET ADDRESS <u>107 Woods Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mr. John Stephen J. Burke</u> First Last		4. DATE OF DEATH Month <u>March</u> Day <u>9th</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 26, 1916</u>
9. AGE (In years last birthday) <u>40 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bethlehem Shipyard</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John M. Burke</u>	
14. MOTHER'S MAIDEN NAME <u>Ann M. King</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT <u>Mrs. Mary J. Burke, 107 Woods Ave.</u> Address <u>Ferndale, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>DROWNING</u> <u>223 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>CAR RAN OFF ROAD INTO BEAR CREEK</u>	
20c. TIME OF INJURY Month, Day, Year <u>17th Nov 3-9 1957</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Ben Luke Rd - 5 SPAN</u>	20f. (City or town) <u>Dundalk</u> (County) <u>Baltimore</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M. B. Davis</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. DAVIS MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/12/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck 5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>Mar 12 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Am. M. Kelly</u>	

BUREAU V. 3

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## 02580 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SPARROWS PT.</b>		c. LENGTH OF STAY IN 1b <b>11 YR.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE (19)</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Best Steel Dispensary</b>				d. STREET ADDRESS <b>2115 SPARROWS POINT RD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>RADFORD</b> Last <b>CAMPBELL</b>				4. DATE OF DEATH Month <b>3</b> Day <b>15</b> Year <b>1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 11, 1919</b>		9. AGE (In years last birthday) <b>38</b> yrs.	10. IF UNDER 1 YEAR Months <b>3</b> Days <b>15</b>	11. IF UNDER 24 HRS. Hours <b>57</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STEEL WORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BECKLEY, W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES HENRY CAMPBELL</b>				14. MOTHER'S MAIDEN NAME <b>NINA COFFEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>2ND</b>		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> <b>1.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1.8</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18.) <b>Disappeared while Ducking in Ches Bay</b>					
20c. TIME OF INJURY Hour <b>1/2</b> a.m. <b>1/2</b> p.m. <b>1/2</b> Year <b>1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Ches Bay</b>		20f. (City or town) (County) (State) <b>Md Sp Pt Balto. Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>M B Davis MD</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3/15/57</b>			
EXAMINER'S NAME (Type) <b>M. B. DAVIS MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or OTHER (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-18-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Family Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Lanham Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Hinde Bradley, Dundalk, Md</b>				24a. REC'D BY REGISTRAR <b>DATE 18 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Lawsorth Fickley</b>	

THIS MEDICAL EXAMINER'S CERTIFICATE should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MAR 19 1957

BUREAU V. S.

## 02581 CERTIFICATE OF DEATH

Reg. Dist. No. 37

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Matthews Rd</u>				d STREET ADDRESS <u>Matthews Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARMIDE Courtney Chilcoat</u>				4. DATE OF DEATH Month Day Year <u>March 12 1957</u>			
5 SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8 June 1882</u>	
9 AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11 BIRTHPLACE (State or foreign country) <u>Sweet Air Bldg Co</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Asel Gittings Wilson</u>				14 MOTHER'S MAIDEN NAME <u>Hattie Elizabeth Silver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Daughter Co. Lawrence Pl. Park Road, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vascular disease</u> <u>47.2.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u>							
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Monkton</u>				20g. (County) <u>Md.</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>August 4</u> , 19 <u>56</u> , to <u>March 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12 March</u> , 19 <u>57</u> , and that death occurred at <u>9:40 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter T. Kees</u>				ADDRESS (Street, city or town, state) <u>Cockeyville Md</u>			
DATE SIGNED <u>12 March 1957</u>							
PHYSICIAN'S NAME (Type) <u>WALTER T. KEES</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-14-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. James Episcopal</u>		22d. LOCATION (City, town, or county) (State) <u>Monkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Scott Brooks</u>				ADDRESS <u>Towson 4, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>3/13/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. J. Chilcoat</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 1 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02582 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02572

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>252 1/2 Clifton Rd.</b>				e. STREET ADDRESS <b>853 Arneliff Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Michael</b> Last <b>Glem</b>				4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (in years last birthday) <b>37</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>				13. FATHER'S NAME <b>Clarence E. Glem</b>			
14. MOTHER'S MAIDEN NAME <b>Betty Pears</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			
16. SOCIAL SECURITY NO. <b>1-12-345678</b>				17. INFORMANT <b>George J. Gonce</b> Address <b>2212 N. ...</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis due to volvulus of small intestine</b> <b>570.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>570.3</b> DUE TO (a), stating the underlying cause lost. (c) <b>570.3</b> DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>570.3</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M. D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>March 11-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>AA Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Gonce</b>				24a. REC'D BY REGISTRAR <b>Edith Harlowe</b>			
				24b. REGISTRAR'S SIGNATURE <b>Edith Harlowe</b>			

MAR 14 1957

BUREAU V. S.

MAR 14 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02583

## CERTIFICATE OF DEATH

Reg. Dist. No.

02573 32

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. LENGTH OF STAY IN 1b <u>15 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>4114 Colby Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Araminta</u> Middle <u>Matilda</u> Last <u>Comegys</u>		4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>June 13, 1863</u>
9. AGE (In years last birthday) <u>93</u> yrs		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin J. Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ann Dennis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. W. Carroll Comegys</u>		Address <u>Pikesville</u> <u>4114 Colby Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO <u>7/2/1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Sclerosis</u> (c) <u>Art. Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>2 yrs</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>55</u> , to <u>Mar. 6th</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 6</u> , 19 <u>57</u> , and that death occurred at <u>1 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James A. Miller</u>		ADDRESS (Street, city or town, state) <u>1331 Reisterstown Rd, Pikesville, Md.</u>	
NAME (Type) <u>James A. Miller, M.D.</u>		DATE SIGNED <u>3/8/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 9, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank D. ...</u>		24a. REC'D BY REGISTRAR <u>  </u>	
ADDRESS <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

BUREAU V. 2

MAR 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02584

CERTIFICATE OF DEATH

Reg. Dist. No.

02574

1 PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Nicodemus Rd.</u>				d. STREET ADDRESS <u>Nicodemus Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>MELVIN</u> Middle <u>L.</u> Last <u>CONSTANTINE</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> <u>DECEASED</u>	8. DATE OF BIRTH <u>Nov. 9, 1904</u>		9. AGE (In years last birthday) <u>52</u> yrs.	10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James L. Constantine</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Gerber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>Mrs. Thelma W. Constantine-Nicodemus Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Melanomatosis</u> <u>1 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Melanoma of rt. side of neck</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>none</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>none</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-14-59</u> , 19 <u>59</u> , to <u>3-3-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-1-57</u> , 19 <u>57</u> , and that death occurred at <u>10A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>D. D. Caples</u>				ADDRESS (Street, city or town, state) <u>6 Hanover Rd.</u>		DATE SIGNED <u>3-5-57</u>	
PHYSICIAN'S NAME (Type) <u>D. D. Caples, M. D.</u>				<u>Reisterstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tuckner &amp; Sons - Balto 17 Md</u>				24a. REC'D BY REGISTRAR <u>DATE 3/6/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Elmy</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. M.

18 9 1957

RECEIVED

02585

02575

37

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE [Where deceased lived If institution- Residence before admission] a. STATE <b>Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>				c. LENGTH OF STAY IN 1b <b>6 WEEKS</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE CITY. 3V</b>				d. STREET ADDRESS <b>1647 COVINGTON ST.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DANIEL</b> Middle <b>LEROY</b> Last <b>COPPER</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>28</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/2/95</b>	
9. AGE (In years last birthday) <b>62 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LOCOMOTIVE ENGINEER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>			
11. BIRTHPLACE (State or foreign country) <b>Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
13. FATHER'S NAME <b>JOHN COPPER</b>				14. MOTHER'S MAIDEN NAME <b>MATILDA WEBBER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WWI.</b>				16. SOCIAL SECURITY NO <b>UNKNOWN</b>			
17. INFORMANT Address <b>Hospital records, Mt. Wilson State Hospital</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRAIN HEMORRHAGE</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROSIS.</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULMONARY TUBERCULOSIS</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>2-8-</b> 1957, to <b>3-28-</b> 1957, that I last saw the deceased alive on <b>3-28-</b> 1957, and that death occurred at <b>1:45</b> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.							
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D. Supt. Mt. Wilson, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 1, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>1 Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCall F...</b> ADDRESS <b>Home</b>				24a. REC'D BY REGISTRAR <b>Barry</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Dorothy Newell</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 1900

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02552

Item 1

CERTIFICATE OF DEATH

02576

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 27</u>				c. LENGTH OF STAY IN 1b <u>1 yr 3 mos</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2101 Smith Ave.</u>				d. STREET ADDRESS <u>2101 Smith Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROTH</u> <u>E.</u> <u>CROUT</u>				4. DATE OF DEATH Month Day Year <u>March</u> <u>22</u> <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct-5-1875</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>			
11. BIRTH PLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Verale</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>1</u>			
17. INFORMANT <u>William E. J. Hoff</u>				Address <u>2101 Smith Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C-V-D</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Hemorrhage with Ht. hemiparesis - 2 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Jan 14</u> , 1956, to <u>March 22</u> , 1957, that I last saw the deceased alive on <u>Feb. 11</u> , 1957, and that death occurred at <u>5:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Arthur Rossberg M.D.</u>				ADDRESS (Street, city or town, state) <u>2436 Washington Blvd Baltimore - 30 Md.</u>			
PHYSICIAN'S NAME (Type) <u>C. ARTHUR ROSSBERG M.D.</u>				DATE SIGNED <u>3/22/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/22/57</u>		<u>St. Agnes Cemetery</u>		<u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William E. J. Hoff</u>				ADDRESS <u>1614 Cassell Ave</u>		24a. REC'D BY REGISTRAR DATE <u>3/22/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Don M. Tuffy</u>			

RECEIVED

MAR 20 1967

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 212

02553

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02577

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto. Highlands</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto. Highlands, Balto. 27, Md</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2811 Florida Ave.</b>				d. STREET ADDRESS <b>2811 Florida Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Francis David Cusly</b>				4. DATE OF DEATH Month Day Year <b>Mar. 23, 1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 16, 1901</b>		9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rivet Heater</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ship Yard</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William F Cusly</b>				14. MOTHER'S MAIDEN NAME <b>Anno R Sanders</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>215 00 3156</b>		17. INFORMANT Address <b>Annette Cusly. 2811 Florida Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Acute cardiac failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio Vascular disease</b> DUE TO (c) <b>Cardio Vascular disease</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Geo. S. M. Kieffer</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Geo. S. M. Kieffer M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>3/26/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Balto. National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Flynn &amp; Fleming 1726 Light St.</b>				24a. REC'D BY REGISTRAR <b>MAR 26 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Geo. S. M. Kieffer</b>	

RECEIVED  
APR 20 1957  
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02542 CERTIFICATE OF DEATH

02578

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>204 DETROIT AVENUE</u>				d. STREET ADDRESS <u>204 DETROIT AVE.</u>			
3. NAME OF DECEASED (Type or print) First <u>LEO</u> Middle <u>AGUSTINE</u> Last <u>CYPHERT</u>				4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 16-1877</u>	9. AGE (In years last birthday) <u>79</u> yrs	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House (Self Employed)</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Leo G. Cyphert</u>				14. MOTHER'S MAIDEN NAME <u>Rhodes McDonald (1)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>MRS. Charlotte R. Cyphert (Above)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic C. V. disease</u> DUE TO <u>Periculous Anemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Rheumatoid Arthritis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u> <u>yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>57</u> , to <u>Mar 27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Mar 27</u> , 19 <u>57</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen C. Mochanale</u> M.D.				ADDRESS (Street, city or town, state), <u>6714 Holbrook Ave Baltimore 22 Md 3-2857</u>			
PHYSICIAN'S NAME (Type) <u></u>				DATE SIGNED <u>Mar 29 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-30-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. CATHERINE CEMETERY DuBois - Pennsylvania</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Ruff Bradley, Dundalk, Md</u>				24a. REC'D BY REGISTRAR <u>Mar 29 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mr. Kelly</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 28 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Res. dence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CALANSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSKVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>502 ACADEMY RD.</u>				d. STREET ADDRESS <u>502 ACADEMY RD.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA M. DARNELL</u>				4. DATE OF DEATH Month Day Year <u>MAR. 1 1957</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 16, 1876</u>	9. AGE (In years last birthday) <u>80</u> yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>O.H.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>BENJAMIN SWANN</u>				14. MOTHER'S MAIDEN NAME <u>SARAH ANDE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT Address <u>James W. Darnell (SON) 502 Academy Rd</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ischemic cerebrovascular disease - vascular disease with failure</u> DUE TO (b) <u>discrete with failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>---</u> DUE TO (c) <u>---</u>							INTERVAL BETWEEN ONSET AND DEATH <u>---</u> yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 <u>---</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>57</u> , to <u>3/1/57</u> , 19 <u>---</u> , that I last saw the deceased alive on <u>2/4/57</u> , 19 <u>---</u> , and that death occurred at <u>250</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>James W. Darnell MD</u> M.D. <u>2030 Harrison Ave</u> <u>3/1/57</u>							
PHYSICIAN'S NAME (Type) <u>Benjamin Swann</u> <u>William W.</u> <u>2030 Harrison Ave</u> <u>3/1/57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR. 4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>		22d. LOCATION (City, town, or county) (State) <u>WOODLAWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Kistner</u> ADDRESS <u>4101 EDMONDSON AVE</u>				24a. REC'D BY REGISTRAR DATE <u>3/6/57</u>		24b. REGISTRAR'S SIGNATURE <u>Rich Hedrick</u>	

BUCHANAN V. S.

1957

1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02587 CERTIFICATE OF DEATH

025878

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parryville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parryville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7715 Wilson Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mr. Oliver L.</i> Middle <i>Davidson</i> Last <i>Davidson</i>		4. DATE OF DEATH Month <i>March</i> Day <i>22nd</i> Year <i>1957</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 5, 1870</i>
9. AGE (In years last birthday) <i>86</i> yrs.		IF UNDER 1 YEAR Months <i>6</i> Days <i>16</i> Hours <i>16</i> Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Sears Roebuck</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Detroit, Michigan</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Auron Davidson</i>		14. MOTHER'S MAIDEN NAME <i>Bertha Mc Gregor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO. <i>212-10-4134</i>	
17. INFORMANT Address <i>Mrs. Gertrude A. Davidson, 7715 Wilson Ave</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>central thrombosis</i> DUE TO <i>atherosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>atherosclerosis</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2-10</i> , 19 <i>54</i> , to <i>3-22</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>3-22</i> , 19 <i>57</i> , and that death occurred at <i>12:30</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank W. Davis Jr.</i>		DATE SIGNED <i>3/22/57</i>	
PHYSICIAN'S NAME (Type) <i>Frank W. Davis Jr.</i>		ADDRESS (Street, city or town, state) <i>11 E. Chase St</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/25/1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem Park</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Hargford Road #04</i>	
24a. REC'D BY REGISTRAR <i>APR 26 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Dr. H. M. Brown</i>	

BUREAU V. S.

MAR 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02588

## CERTIFICATE OF DEATH

02581

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) c. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>74 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1601 Ceddox Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>E.</b> Last <b>DELOST</b>				4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 15, 1926</b>	
9. AGE (In years last birthday) yrs <b>30</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chemical operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Chemical Plant</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Frank</b>				14. MOTHER'S MAIDEN NAME <b>Anna ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Korea</b>		17. INFORMANT <b>Family - Same</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HODGKIN'S DISEASE, GENERALIZED, VISCERAL</b> <b>201X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
70a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> attended the deceased from <b>January 7, 1957</b> to <b>March 22, 1957</b> that I saw the deceased alive on <b>March 22, 1957</b> and that death occurred at <b>9:40 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Rolando D. Ponce de Leon</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b>				DATE SIGNED <b>3/22/57</b>			
PHYSICIAN'S NAME (Type) <b>ROLANDO D. PONCE DE LEON, M.D. VAH, FORT HOWARD, MARYLAND</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/26/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Homes - 130 E. Fort Ave.</b>				24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>L. L. Lacey</b>	

RECEIVED

MAR 26 1957

BUREAU V. E.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the registrar prior to removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
02589 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02582

Reg. Dist. No.

53

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>5 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 3rd-4</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Reisterstown Road</b>				d. STREET ADDRESS <b>3320 Moravia Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>DeRosa</b> Last <b>DeRosa</b>				4. DATE OF DEATH Month <b>Mar.</b> Day <b>2</b> Year <b>1957</b>			
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 1, 1909</b>		9. AGE (In years last birthday) <b>47</b> yrs.	IF UNDER 1 YEAR Months <b>4</b> Days <b>17</b>	IF UNDER 24 HRS. Hours <b>17</b> Min. <b>45</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Post office-Baltimore City</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Delta, Pa.</b>		11. BIRTHPLACE (State or foreign country) <b>Delta, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Louis DeRose</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Concheeta DeRosa, 3320 Moravia Ave., Balto.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic C-V Disease</b> (a), stating the underlying cause last. DUE TO (c) <b>none</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>D. D. Corles</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>D. D. Corles, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>3-4-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-6-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruch, Inc., 5305 Harford Rd. Balto., Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 3-4-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>	

MEDICAL CERTIFICATION

UNITED V. S.

NO. 1

REG. NO. 1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02590

## CERTIFICATE OF DEATH

02583

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b> c. LENGTH OF STAY IN 1b <b>4 YEARS, 5 MONTHS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSP.</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>ANNE ARUNDEL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LINTHICUM</b> d. STREET ADDRESS <b>200 N. HAMMONDS FERRY RD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EMMA</b> First <b>LEE</b> Middle <b>DINSMORE</b> Last		4. DATE OF DEATH Month <b>3</b> Day <b>15</b> Year <b>1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-15-1863</b>
9. AGE (In years last birthday) <b>94</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>WILLIAM DINSMORE</b>		14. MOTHER'S MAIDEN NAME <b>MARY CUMMINGS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS. CHARLES HARE</b>		Address <b>200 N. HAMMONDS FERRY RD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>			INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>10/23</b> , 19 <b>53</b> , to <b>3/15</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3/15</b> , 19 <b>57</b> , and that death occurred at <b>10:45 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D.		ADDRESS (Street, city or town, state) <b>Spring Grove State Hosp.</b> DATE SIGNED <b>3/16/57</b>	
PHYSICIAN'S NAME (Type) <b>STELLA WACHSLER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>BURIAL</b>	<b>3-19-57</b>	<b>Rock Hill</b>	<b>Harford Co.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John W. Wachslar</b> ADDRESS <b>1517 State St.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 18 57</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. Houch</b>

MEDICAL CERTIFICATION

2

1

14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02584

## 02591 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ridgway Nursing Home, Edmondson Ave</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> d. STREET ADDRESS <u>7015 Alden Rd. Pikesville</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Annie</u> Middle <u>E.</u> Last <u>Doberer</u>				<b>4. DATE OF DEATH</b> Month <u>Mch.</u> Day <u>17</u> Year <u>1957</u>													
<b>5. SEX</b> <u>Fem.</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. <del>WEDDED</del> NEVER MARRIED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Sep. 15, 1879</u>		<b>9. AGE</b> (In years last birthday) <u>86</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Never Worked</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>none</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>									
<b>13. FATHER'S NAME</b> <u>George J. Doberer</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Louisa List</u>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>no</u>		<b>17. INFORMANT</b> Address <u>Mrs. Charles A. Jones 7015 Alden Rd.</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>Hypertensive Cardiovascular disease</u> DUE TO (b) <u>Fracture of the left leg. (Hip) Femur</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Accident.</u>								INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pin operation St. Agnes Hosp. Feb. 9, 1957</u>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Fall</u> <u>Fall out of bed, climbing over side of bed to use comode</u>													
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>3 A.M. Feb. 3, 1957</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u>		<b>20f. (City or town)</b> (County) (State) <u>Catonsville Balto. Co. Md.</u>									
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
<b>ACTUAL SIGNATURE</b> <u>Geo. S. M. Kieffer</u> <b>EXAMINER'S NAME (Type)</b> <u>Geo. S. M. Kieffer M. D.</u>					<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>												
<b>DATE SIGNED</b> <u>March 17, 57.</u>																	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>			<b>22b. DATE THEREOF</b> <u>3/20/57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park Cem.</u>			<b>22d. LOCATION</b> (City, town, or county) (State) <u>Balto., Md.</u>									
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Geo. J. Kieffer &amp; Sons - Balto</u>					<b>24a. REC'D BY REGISTRAR</b> <b>24b. REGISTRAR'S SIGNATURE</b> DATE <u>3/19/57</u> <u>H. H. Hedrich</u>												

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the County Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAR 20 1907

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may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered to the funeral director for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02592 CERTIFICATE OF DEATH

025857

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>PRINCE GEORGE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HILLSIDE 16</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		e. STREET ADDRESS <b>1603 - 61st Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle <b>HARVEY</b> Last <b>DOUGLAS</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>30</b> Year <b>1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/27/93</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>	
11. BIRTHPLACE (State or foreign country) <b>D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JOHN C. DOUGLAS</b>		14. MOTHER'S MAIDEN NAME <b>KATHERLEEN HANNIN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>578-09-4511</b>	
17. INFORMANT <b>Hospital records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>002X</b> IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/25</b> , 19 <b>57</b> , to <b>3/30</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3/30</b> , 19 <b>57</b> , and that death occurred at <b>5:20</b> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.			
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D. Supt. Mt. Wilson, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>April 13, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 5 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Sorothy Jewell</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02593 CERTIFICATE OF DEATH

02586 38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8311 Edgedale Road</u>		d. STREET ADDRESS <u>8311 Edgedale Road</u>	
3. NAME OF DECEASED (Type or print) <u>Miss Catherine G. Durkan</u>		4. DATE OF DEATH <u>March 19th</u> 19 <u>57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1897</u>
9. AGE (In years last birthday) <u>59 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Senior Clerk, Metropolitan Life Ins</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Durkan</u>		14. MOTHER'S MAIDEN NAME <u>Mary Clancy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Miss May Durkan, 8311 Edgedale Road #14</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>158X</u> DUE TO <u>Retro-Peritoneal Mass</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Probably Malignant</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>57</u> , to <u>March 18</u> 19 <u>57</u> that I last saw the deceased alive on <u>3/19/57</u> , 12 <u>2:30 PM</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dennis McGrath</u>		ADDRESS (Street, city or town, state) <u>8358 Loch Raven Blvd.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Dennis Mc Grath</u>		DATE SIGNED <u>3/20/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/23/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryl and</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR <u>Dr. L. M. Bacon</u>	
ADDRESS <u>5305 Harford Road #14</u>		24b. REGISTRAR'S SIGNATURE	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
02594 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02587  
Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>		c. LENGTH OF STAY IN lb <b>6 mos.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>341 Endsleigh Ave.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waynesboro Pa</b>	
3. NAME OF DECEASED (Type or print) <b>Carrie Mentzer Durst</b>		4. DATE OF DEATH <b>March 4, 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 20, 1882</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Mentzer</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Royer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>204-017-169</b>	
17. INFORMANT <b>Arthur J. Durst</b>		Address <b>341 Endsleigh Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A-S-C-V. Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>TOXICIOUS ANEMIA</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>M.B. Davis M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>M.B. Davis M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>3/4/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>3-5-1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenhill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Waynesboro, Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James J. Bruzdinski</b>		ADDRESS <b>1407 Eastern Ave.</b>	
24a. REC'D BY REGISTRAR <b>DATE 3/5/57</b>		24b. REGISTRAR'S SIGNATURE <b>Edith Hurley</b>	

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MAR 15 1955

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02595 CERTIFICATE OF DEATH

Reg. Dist. No. 02588

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor Nursing Home</b>		d. STREET ADDRESS <b>603 N. Augusta Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Cloveland</b> Last <b>Egner</b>		4. DATE OF DEATH Month <b>March</b> Day <b>5</b> , Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 21, 1892</b>
9. AGE (In years last birthday) yrs. <b>64</b>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Tavern Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Egner</b>		14. MOTHER'S MAIDEN NAME <b>Clara Cook</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Helen Egner, 603 N. Augusta Ave</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, Cerebral, Metastatic</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma, Squamous, Jaw, right</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b> <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>Carcinoma, Adenocarcinoma, Sigmoid</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-15</b> , 19 <b>55</b> to <b>3-5</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3-5</b> , 19 <b>57</b> , and that death occurred at <b>3 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John F. Schaefer</b>		ADDRESS (Street, city or town, state) <b>401 RANDOLM-BALTO. 29</b>	
PHYSICIAN'S NAME (Type) <b>JOHN F. SCHAEFER MD.</b>		DATE SIGNED <b>3/6/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 8/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore 29 Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry H. Witzke, 4101 Edmondson Ave.</b>		24a. REC'D BY REGISTRAR <b>MAR 11 57</b>	
24b. REGISTRAR'S SIGNATURE <b>Witzke</b>			

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MAR 11 1957

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MAR 11 1957

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02596 CERTIFICATE OF DEATH

Reg. Dist. No.

02589 37

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson</u>			c. LENGTH OF STAY IN 1b <u>2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <u>STOCKTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>				d. STREET ADDRESS <u>SAME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <u>GROVER</u> Middle <u>Co.</u> Last <u>ELLIS</u>				<b>4. DATE OF DEATH</b> Month <u>MARCH</u> Day <u>7</u> Year <u>1957</u>				
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>6-8-1892</u>		
<b>9. AGE</b> (In years last birthday) <u>64 yrs.</u>		<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>FISHERMAN</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>SAME</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>GREENBACKVILLE, Va</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>CHARLES ELLIS</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>MOLLY Bowen</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>214-16-4131</u>		<b>17. INFORMANT</b> Address <u>Hospital records, Mt. Wilson State Hospital</u>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY TUBERCULOSIS, FAR ADVANCED</u>							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. _____ p. m. _____ 19____			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>10/1/57</u> , 19 <u>57</u> , to <u>3/7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/7</u> , 19 <u>57</u> , and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____								
<b>ACTUAL SIGNATURE</b> <u>William Newcomer</u> M.D. _____								
<b>PHYSICIAN'S NAME</b> (Type) <u>William Newcomer, M.D. Surt.</u> <u>Mt. Wilson, Maryland</u>								
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial March 14/57</u>		<b>22b. DATE THEREOF</b> <u>March 14/57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Centersville, Kentucky</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Stockton</u> <u>MD</u>		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>Clayton Harris, Snow Hill, Md.</u>				<b>24a. REC'D BY REGISTRAR</b> DATE <u>March 15 1957</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Norothy Newells</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

MAR 11 1957

RECEIVED

02597

## CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b. <u>41 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hanover Pike</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Elwood</u> Last <u>Elwood</u>		4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 14, 1879</u> 77 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Charles Elwood</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Cunniff</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Onida Elwood, Baltimore, Md</u> Address <u>—</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Hypertensive Cardio-Renal Vascular Disease</u> DUE TO <u>Generalized Atherosclerosis</u> Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>	
21. I certify that I attended the deceased from <u>August 1, 1957</u> , to <u>March 22, 1957</u> , that I last saw the deceased alive on <u>March 19, 1957</u> , and that death occurred at <u>9:18 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		DATE SIGNED <u>3/22/57</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		<u>Hampstead Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 25/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT Gilman</u>	22d. LOCATION (City, town, or county) (State) <u>Woodbury Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw O Tipton</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>DATE 3-23-57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mary B Stone</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Items 18&20 Film 213 4/4/57 amc									
02593 CERTIFICATE OF DEATH									
Reg. Dist. No. 02591 37									
1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Augsburg Lutheran Home</b>					d. STREET ADDRESS <b>3612 Gwynn Oak Ave.</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>ELEANORA</b> Middle <b>MARIE</b> Last <b>ENGEL</b>					4. DATE OF DEATH Month <b>Mar.</b> Day <b>17</b> Year <b>19 57</b>				
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 27, 1876</b>		9. AGE (In years last birthday) <b>80</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>William Frederick Buschardt</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <b>none</b>				
17. INFORMANT <b>Mr. Harry J. Engel</b>					Address <b>129 N. 19th St., Camp Hill Penna.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.0 Arterio-sclerotic Heart Disease</b> DUE TO (b) <b>Generalized Arterio-sclerosis</b> DUE TO (c) <b>Generalized Arterio-sclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>17.7 Second degree burns</b>									
INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Heart attack - fell against hot radiator - not able to move for sometime</b>				
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m. Mar 11 1957</b> p. m.					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Augsburg Home</b>					20f. (City or town) <b>Balto. Co.</b> (County) <b>Maryland</b> (State)				
21. I certify that I attended the deceased from <b>Oct 8, 1953</b> , to <b>March 17, 1957</b> , that I last saw the deceased alive on <b>March 17, 1957</b> , and that death occurred at <b>Md.</b> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>Earl L. Chambers</b>					ADDRESS (Street, city or town, state) <b>4108 Liberty Hts. - Baltimore 7 - Md.</b>				
DATE SIGNED <b>3-19-57</b>									
PHYSICIAN'S NAME (Type) <b>Earl L. Chambers</b>					ADDRESS <b>4108 Liberty Hts - Balto - 7 - Md.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>3/20/57</b>				
22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cem.</b>					22d. LOCATION (City, town, or county) <b>Violetville, Md.</b> (State) <b>3-19-57</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Zolner</b>					ADDRESS <b>177 W. 1st St. - Balto.</b>				
24a. REC'D BY REGISTRAR <b>Dr. Wm. E. Martin</b>					DATE <b>3/19/57</b>				

BUREAU V. B.

MAR 20 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02599 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02592

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1 Overlea Avenue</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u> d. STREET ADDRESS <u>White Marsh Road</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Carolyn</u> First <u>Dorsey</u> Middle <u>Field</u> Last				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>23</u> Year <u>1957</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Feb. 16, 1957</u>			
<b>9. AGE</b> (In years last birthday) yrs. <u>1</u> Months <u>7</u>		<b>10. IF UNDER 1 YEAR</b> Hours <u>1</u> Min. <u>0</u>		<b>11. IF UNDER 24 HRS.</b> Hours <u>1</u> Min. <u>0</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Baby</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>At Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore, Maryland</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>				<b>13. FATHER'S NAME</b> <u>John Fields</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Phyllis Board</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Family records</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>191X</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour <u>19</u> a. m. <u>19</u> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Residence</u>			
<b>20f. (City or town)</b> <u>Towson</u>		<b>20g. (County)</b> <u>Baltimore</u>		<b>20h. (State)</b> <u>Maryland</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> <u>Natural causes</u> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined cause</b> <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>William J. Board</u>		<b>EXAMINER'S NAME</b> (Type) <u>William J. Board</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DATE SIGNED</b> <u>3-23-57</u>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Mar. 25, 1957</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Prospect Hill Cemetery</u>			
<b>22d. LOCATION</b> (City, town, or county) <u>Towson, Maryland</u>		<b>22e. (State)</b> <u>Maryland</u>		<b>22f. REGISTRAR'S SIGNATURE</b> <u>Wm. L. Board</u>			
<b>22g. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. L. Board</u>		<b>22h. ADDRESS</b> <u>Towson, Maryland</u>		<b>22i. REC'D BY REGISTRAR</b> <u>Wm. L. Board</u>			
<b>22j. DATE</b> <u>3-23-57</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

REAU V. S.

MAR 23 1937

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02610

## CERTIFICATE OF DEATH

0259344

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>16 days</b>		d. STREET ADDRESS <b>9735 Harford Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>J</b> Last <b>FINN, SR.</b>		4. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>11/26/10</b>
9. AGE (In years last birthday) <b>46</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Finn</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Hines</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>WWII</b>		16. SOCIAL SECURITY NO. <b>214-18-3840</b>	
17. INFORMANT <b>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HODGKINS DISEASE VISCERAL GENERALIZED</b> <b>11X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <b>BRONCHOPNEUMONIA RIGHT LATERAL</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>February 21, 1957</b> , to <b>March 9, 1957</b> , and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Rolando P. Ponce de Leon</b> M.D.		ADDRESS (Street, city or town, state) <b>Veterans Administration Hospital</b> DATE SIGNED <b>3/9/57</b>	
PHYSICIAN'S NAME (Type) <b>ROLANDO D. PONCE DE LEON, M.D.</b> <b>Fort Howard, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-12-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount Marie Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Towson, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM. COOK-BLIGHT FUNERAL HOME, INC. 6009 Harford Rd. Baltimore, Md.</b>		24a. REC'D BY REGISTRAR <b>3/11/57</b>	24b. REGISTRAR'S SIGNATURE <b>Dawson L. Fairley</b>

BUREAU N. 3

MAR 12 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02601

## CERTIFICATE OF DEATH

0259A

Reg. Dist. No.

18

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ivy Hall Conv. Home</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Middle River</u>			
3. NAME OF DECEASED (Type or print) <u>George F. Fisher</u>				4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>21 June 1897</u>		9. AGE (In years lost birthday) yrs. <u>59</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. County</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Fisher</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Lay</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Henry R. Fisher</u> Address <u>Box 16 White Marsh, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis, Generalized</u> DUE TO (b) <u>Carcinoma of esophagus</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cachexia, advanced</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>				20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I attended the deceased from <u>March 7</u> , 19 <u>57</u> , to <u>March 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 9</u> , 19 <u>57</u> , and that death occurred at <u>2 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Ridge Road</u> DATE SIGNED <u>Mar. 12 1957</u>							
ACTUAL SIGNATURE <u>Harvey L. Fuller</u> M.D.				DATE SIGNED <u>Mar. 12 1957</u>			
PHYSICIAN'S NAME (Type) <u>Harvey L. Fuller</u>				ADDRESS <u>Baltimore 6, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Paul Luthern</u>		22d. LOCATION (City, town, or county) (State) <u>R.D. Aberdeen, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Harrington</u>				24a. REC'D BY REGISTRAR <u>Mar. 13-57</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Stanley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR. 11 1908

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**02602 MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 02595

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> <span style="float: right;">b. COUNTY <b>Balto.</b></span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>52</b> <b>Catonsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>501 Maryland Ave.</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>IRMA</b> <span style="float: right;">First Middle Last</span> <b>Irma N. Folker</b>		<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>14</b> Year <b>19 57</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>12/13/25</b> <span style="float: right;">9. AGE (In years last birthday) <b>32</b> yrs.</span>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Domestic</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Balto Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>	
<b>13. FATHER'S NAME</b> <b>James McCann</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Bayer</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT</b> <b>Frank Folker Jr.</b> <span style="float: right;">Address</span>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor pulmonale</b> <b>Chronic passive congestion of lungs, liver and spleen</b> Conditions, if any, which gave rise to immediate cause (b) <b>and spleen</b> (c), stating the underlying cause last. <b>Congenital heart disease</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>19</b> <span style="float: right;">a. m. p. m.</span>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <b>William V. Lovitt, Jr.</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASS STANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>	
<b>EXAMINER'S NAME (Type)</b> <b>William V. Lovitt, Jr., M.D.</b>		<b>DATE SIGNED</b> <b>3/15/57</b>	
<b>22a. BURIAL, CREMATION, OR REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>3/18/57</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>National</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Balto Md.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Mac Pratt</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE MAR 19 57</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <b>W. H. Beach</b>			

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02603 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02596

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGE MERE</u>		c. LENGTH OF STAY IN 1b <u>15 YRS</u>		a. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGE MERE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>36 WILLOW AVE</u>			d. STREET ADDRESS <u>36 WILLOW AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLOYD JAMES FORBES</u>			4. DATE OF DEATH Month Day Year <u>MARCH 5 1957</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 17, 1905</u>		9. AGE (In years last birthday) <u>51</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALBERT L. FORBES</u>			14. MOTHER'S MAIDEN NAME <u>ADA RANDOLPH</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>MATTHEW FORBES</u> Address <u>36 WILLOW AVE - 19</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO (b) <u>A-S-C-D-DISEASE</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>					INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>	
20f. (City or town) <u>None</u>		20g. (County) <u>None</u>		20h. (State) <u>None</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>M. B. Davis</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>M. B. DAVIS M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>MAR 7, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CRAIGSVILLE</u>	
22d. LOCATION (City, town, or county) <u>CRAIGSVILLE VA</u>		22e. (State) <u>VA</u>		22f. (Country) <u>U.S.A.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME 2112 DUNDALK</u>			24a. REC'D BY REGISTRAR DATE <u>3/6/57</u>		
			24b. REGISTRAR'S SIGNATURE <u>Dawson L. Laker</u>		

44

BUREAU V. S.

MAR 8 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02604

## CERTIFICATE OF DEATH

02597

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XO Pkosville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hooks Lane</b>				d. STREET ADDRESS <b>Hooks Lane</b>			
3. NAME OF DECEASED (Type or print) First <b>EARL</b> Middle <b>A.</b> Last <b>FRANKE</b>				4. DATE OF DEATH Month <b>Mar.</b> Day <b>9</b> Year <b>1957</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 2, 1881</b>	9. AGE (In years last birthday) <b>71</b>	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber (rtd)</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>George Franke</b>				14. MOTHER'S MAIDEN NAME <b>Louisa -</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-22-7077</b>		17. INFORMANT <b>Rev. Edmond L. Gattier, Jr. - Claggett Center</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>arteriosclerosis</b> DUE TO <b>arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>3 yrs</b> <b>3 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-1-30</b> to <b>3-9-57</b> , that I last saw the deceased alive on <b>3-8-57</b> , 19 <b>57</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James G. Saffell</b> M.D.				ADDRESS (Street, city or town, state) <b>Reisterstown Md</b> DATE SIGNED <b>3-11-57</b>			
PHYSICIAN'S NAME (Type) <b>James G. Saffell</b>				REISTERSTOWN MD <b>3-11-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/12/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cen.</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Dickerson &amp; Sons - Balto. 17 Md.</b>				24a. REC'D BY REGISTRAR DATE <b>3/11/57</b>		24b. REGISTRAR'S SIGNATURE <b>Martha Newell</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02695 CERTIFICATE OF DEATH

02598

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>Catonville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>241 B. Lakeway Rd</u>		d. STREET ADDRESS <u>241 B. Lakeway Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>STEPHEN RIGGS GILDARD</u>		4. DATE OF DEATH Month Day Year <u>March 9 19 57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 2 1949</u>
9. AGE (In years last birthday) yrs. <u>7</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Calif.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jamer H. Gildard</u>		14. MOTHER'S MAIDEN NAME <u>Whipley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>Jamer H. Gildard</u>	
17. INFORMANT <u>Jamer H. Gildard</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGENITAL CEREBRAL DYSGENESIS</u> <u>753.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>UNKNOWN CAUSES</u> DUE TO (c) <u>POSSIBLE CEREBRAL INFARCTION</u>			INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>  <u>DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-27-</u> , 19 <u>56</u> , to <u>3-9-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-7-</u> , 19 <u>57</u> , and that death occurred at <u>9 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald E. Fisher</u>		ADDRESS (Street, city or town, state) <u>ELLICOTT CITY MD.</u>	
PHYSICIAN'S NAME (Type) <u>DONALD E. FISHER M.D.</u>		<u>ELLICOTT CITY MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>3/11/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fondon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Beth Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Macrae &amp; Son</u>		24. REC'D BY REGISTRAR DATE <u>MAR 12 57</u>	
ADDRESS <u>28</u>		24b. REGISTRAR'S SIGNATURE <u>Elliot</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered to the registrar for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
MAR 12 1957  
BUREAU V. S.

02696

## CERTIFICATE OF DEATH

02599

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>	
c. LENGTH OF STAY in 1b <b>25 yrs.</b>		d. STREET ADDRESS <b>Oakland Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Oakland Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Irving Bernard Gosnell</b>		4. DATE OF DEATH Month Day Year <b>March 1, 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 20, 1888</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer self employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore County</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Irvin Wesley Gosnell</b>		14. MOTHER'S MAIDEN NAME <b>Emma D. Beasman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Irvin B. Gosnell Jr.</b>		Address <b>Reisterstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4-0-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Bronchitis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>
20f. (City or town) <b>none</b>		(County) (State)	
21. I certify that I attended the deceased from <b>July 20, 1954</b> , to <b>Mar. 1, 1957</b> , that I last saw the deceased alive on <b>Mar. 1, 1957</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>6 Hanover Rd. 3-1-57</b>			
ACTUAL SIGNATURE <b>D. D. Coples</b>		M.D. <b>Reisterstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>D. D. Coples, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>March 4/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wards Chapel</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore County, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>3-1-57</b>	
		24b. REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>	

RECEIVED V. S.

MAR 2

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02607 CERTIFICATE OF DEATH

Reg. Dist. No.

02608

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Phoenix,</b>		c. LENGTH OF STAY IN 1b <b>38 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Old York Rd.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Phoenix, rural X</b>	
d. STREET ADDRESS <b>Old York Rd.</b>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Fred</b> Middle <b>Edward</b> Last <b>Graefe</b>		4. DATE OF DEATH Month <b>3</b> Day <b>7</b> Year <b>57</b>	
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1-27-1887</b>
9 AGE (In years last birthday) yrs. <b>80</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farm owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Edward Graefe</b>		14 MOTHER'S MAIDEN NAME <b>Amelia ?</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17 INFORMANT <b>Mrs. Amelia Streett, Phoenix, Md.</b>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>11 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiac Insufficiency</b> DUE TO <b>14 yrs</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m p m 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1920</b> to <b>Mar 6</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3-6-</b> , 19 <b>57</b> , and that death occurred at <b>8 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Walter M. Hammitt M.D.</b> <b>Boyd</b> PHYSICIAN'S NAME (Type) <b>Walter M. Hammitt</b>			
22a. BURIAL, CREMATION, REBURY (Specify)		22b. DATE THEREOF	
<b>Burial</b>		<b>3-9-57</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Evangelical Reform</b>		<b>Phoenix, Maryland</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>J. Scott Brooks</b>		ADDRESS <b>Towson, Md.</b>	
24a. REC'D BY REGISTRAR <b>3-8-57</b>		24b. REGISTRAR'S SIGNATURE <b>W. M. Hammitt</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 19 1907

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## 02698 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Baltimore	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE		Maryland	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Port Howard	c. LENGTH OF STAY IN 1b	22 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Veterans Administration Hospital				127 East North Avenue			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH		
JAMES		L.	GREESON	March	Month	Day	Year
5. SEX		Male	6. COLOR OR RACE	White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	March 25, 1906
9. AGE (In years last birthday) yrs		50	IF UNDER 1 YEAR		Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Carpenter	10b. KIND OF BUSINESS OR INDUSTRY		School Maintenance	11. BIRTHPLACE (State or foreign country)	
Augusta, Georgia		12. CITIZEN OF WHAT COUNTRY?		U. S. A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Lester Greeson				Carrie Malahey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT			
Yes		Unknown		Clin.Rec., Vet.Adm.Hospital, Ft.Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TUMOR, METASTATIC, RIGHT LOBE OF CEREBELLUM							UNKNOWN
(b) CARCINOMA OF LEFT UPPER LOBE OF LUNG WITH							
(c) BILATERAL BRONCHOPNEUMONIA							UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a. m. p. m.		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
21. I certify that I attended the deceased from February 28, 1957, to March 22, 1957, and that death occurred at 12:40 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Rolando D. Ponce de Leon				ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type) ROLANDO D. PONCE DE LEON, M.D.				VAH, FORT HOWARD, MARYLAND		3/22/57	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Removal		3-23-57		Hillcrest Cemetery		Augusta, Georgia	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR	
Wm Cook-Blight, Inc.				6009 Harford Rd, Balto. Md.		24b. REGISTRAR'S SIGNATURE	
R.E. Elliott & Sons, 1134 Telgair St.				Augusta Georgia		Dewson L. Taylor	

SHIPPED TO:

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MAR 20 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02699 CERTIFICATE OF DEATH

Reg. Dist. No.

02698

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>				c. LENGTH OF STAY IN 1b <b>2 YRS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1415 REGESETER AVENUE</b>				e. STREET ADDRESS <b>1415 REGESETER AVENUE</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>HENRY HARRIS GROB</b>				4. DATE OF DEATH Month Day Year <b>MARCH 6, 1957 19</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>JULY 27, 1891</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRODUCE STALL BROADWAY MARKET</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTIMORE MARYLAND.</b>		11. BIRTHPLACE (State or foreign country) <b>USA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>				13. FATHER'S NAME <b>GROB</b>			
14. MOTHER'S MAIDEN NAME <b>EMMA ELIZ. SYNDER</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <b>MRS. ENMA ELIZ. LUTCHE SAME.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>331X</b> DUE TO <b>Initial cerebral vascular accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cerebral Arterio-sclerosis</b> (c) <b>Cerebral Arterio-sclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 1/2 days</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Oct 1954</b> to <b>March 5, 1957</b> , that I last saw the deceased alive on <b>March 5, 1957</b> , and that death occurred at <b>1 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Israel J. Feinglos</b> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <b>room 6, Balth. Bldg. 31-2nd</b>			
PHYSICIAN'S NAME (Type) <b>ISRAEL J. FEINGLOS</b>				22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			
22b. DATE THEREOF <b>3/8/57</b>				22c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN CEMETERY</b>			
22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND.</b>				23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS INC. BALTIMORE MD.</b>			
24a. REC'D BY REGISTRAR <b>Isa. J. Feinglos</b>				24b. REGISTRAR'S SIGNATURE <b>Isa. J. Feinglos</b>			

BUREAU V. S.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
02610 <i>Baltimore County</i> Item 9 <i>11-11-57</i> et al. 02603									
CERTIFICATE OF DEATH									
Reg. Dist. No. <i>31</i>									
1. PLACE OF DEATH a. COUNTY <i>Swain Cal.</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>md</i> b. COUNTY <i>md</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Thornhill</i>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto</i>				
c. LENGTH OF STAY IN 1b <i>8 yrs</i>					d. STREET ADDRESS <i>3210 Chesley Ave</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Chesley Home</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Maudie</i> First <i>U</i> Middle <i>Guert</i> Last <i>Guert</i>					4. DATE OF DEATH <i>March</i> Month <i>1</i> Day <i>1957</i> Year				
5. SEX <i>F</i>		6. COLOR OF RACE <i>W.</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug 28, 1874</i>		9. AGE (In years last birthday) <i>82</i> yrs.	
								IF UNDER 1 YEAR IF UNDER 24 HRS	
								Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>				
					11. BIRTHPLACE (State or foreign country) <i>Balto md</i>				
13. FATHER'S NAME <i>Hardman Shaw</i>					14. MOTHER'S MAIDEN NAME <i>Clay. Ogilvie</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>					17. INFORMANT <i>Records Aug Home</i> Address <i>6811 Campbell Rd</i>				
16. SOCIAL SECURITY NO. <i>—</i>					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>(1) - Arterio - Sclerotic Heart -</i> <i>440.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>(2) - Cerebral Hemorrhage -</i> DUE TO <i>—</i> (c) <i>—</i>				
					INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs, 2 wks.</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized Arterio - Sclerotic.</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <i>Dec. 30, 1953</i> to <i>March 1, 1957</i> , that I last saw the deceased alive on <i>Feb. 28, 1957</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Earl L. Chambers</i> M.D.					ADDRESS (Street, city or town, state) <i>4108 Liberty Hts Balto - md - 3-2-57</i> DATE SIGNED <i>3-2-57</i>				
PHYSICIAN'S NAME <i>Earl L. Chambers</i>					ADDRESS (Street, city or town, state) <i>4108 Liberty Hts Balto - md - 3-2-57</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>					22b. DATE THEREOF <i>Mar. 4 57</i>				
22c. NAME OF CEMETERY OR CREMATORY <i>Trudgill Pl</i>					22d. LOCATION (City, town, or county) (State) <i>Balto md</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. DeWann</i> ADDRESS <i>6667 Hayford Ave</i>					24a. REC'D BY REGISTRAR <i>APR 5 1957</i> DATE				
					24b. REGISTRAR'S SIGNATURE <i>Dr. J. E. Martin</i>				

MEDICAL CERTIFICATION

U. S.

RECEIVED

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02611 CERTIFICATE OF DEATH

Reg. Dist. No.

0260444

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY in 1b <b>93 days</b>		d. STREET ADDRESS <b>4301 Elderon Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>KENNETH</b> Middle <b>L.</b> Last <b>GUYER</b>		4. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/16/09</b>
9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Display Artist</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>York, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Herbert Guyer</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Giessinger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give year or dates of service) <b>Yes</b> <b>NW II</b>		16. SOCIAL SECURITY NO. <b>215-03-5794</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b>			
4d0.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from <b>December 20, 1956</b> to <b>March 23, 1957</b> , and that death occurred at <b>8:55A</b> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Rolando D. Ponce de Leon</i>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>ROLANDO D. PONCE de LEON, M. D.</b>		<b>VAH, Fort Howard, Md.</b> <b>3/23/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-27-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight Funeral Home, 5009 Harford Rd. Balto., Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 20 1957</b>	
24b. REGISTRAR'S SIGNATURE <i>Dawson L. Lacey</i>			

100-200-100

BUREAU V. S.

MAR 28 1957

RECEIVED

02612

CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>-Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>27411 Balto.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>College Manor</b>				d. STREET ADDRESS <b>2001 Park Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>E.</b> Last <b>GWIN</b>				4. DATE OF DEATH Month <b>Mar.</b> Day <b>17,</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. City Schools</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Thomas Thornton Gwin</b>				14. MOTHER'S MAIDEN NAME <b>Margaret M. Mohler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. L. W. Farinholt - Glenarm, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of breast</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Generalized arteriosclerosis</b> (c) <b>Generalized arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 25</b> , 19 <b>57</b> , to <b>Mar 17</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Mar 17</b> , 19 <b>57</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Emmet C Brown Jr</b>				ADDRESS (Street, city or town, state) <b>M.D. 1161 N. Calvert St</b>		DATE SIGNED <b>3/19/57</b>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/20/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Maus.</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Vickner &amp; Sons - Baltor</b>				24a. RECEIVED BY REGISTRAR DATE <b>3/19/57</b>		24b. REGISTRAR'S SIGNATURE <b>H. H. Dedrich</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02613

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02606

38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Daniel Malone Harris</u>		4. DATE OF DEATH <u>Mar 11 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 31 1891</u>
9. AGE (in years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railway Express, Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>USA</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Chas. Wesley Harris</u>		14. MOTHER'S MAIDEN NAME <u>Molly Mary E. Busick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <u>unk</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Cara (Wife)</u>		Address <u>3022 Texas</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank T. Kasik, Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK T. KASIK, JR.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/14/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parrwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Hargord Road #14</u>	
24a. REC'D BY REGISTRAR <u>Mar 12 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. R. M. Bacon</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAR 12 1957

RECEIVED

02614

## CERTIFICATE OF DEATH

02607 43

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7214 Linden Ave.</b>		e. STREET ADDRESS <b>7214 Linden Ave.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MILLIE NORMAN HARRIS</b>		4. DATE OF DEATH Month Day Year <b>March 12, 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 4, 1873</b>
9. AGE (In years last birthday) yrs <b>83</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>W. Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Unk.</b>		14. MOTHER'S MAIDEN NAME <b>Unk.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Anna M. Rhodes</b>		Address <b>7214 Linden Ave. Overlea, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) <b>Metastatic carcinoma of the cervix, with metastasis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3-24</b> , 19 <b>54</b> to <b>3-12</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3-12</b> , 19 <b>57</b> , and that death occurred at <b>6:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>1 Overlea Ave. Baltimore, Md. 3-14-57</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Richard A. Riegler</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 16, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Holland Funeral Home</b>		24a. REC'D BY REGISTRAR <b>MAR 15 1957</b>	
ADDRESS <b>1631 Druid Hill Ave.</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1957

BUREAU V. B.

## 02615 CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGE FOREST</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGE FOREST RD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5700 WISE AVE</u>				d. STREET ADDRESS <u>5700 WISE AVE</u>			
3. NAME OF DECEASED (Type or print) <u>NELLIE MAE HARRISON</u>				4. DATE OF DEATH <u>MAR 24 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 22 - 1891</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>LAW SIKKIAN</u>			
14. MOTHER'S MAIDEN NAME <u>ELLA CORNHAN</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>JAMES HARRISON</u> Address <u>5700 WISE AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> <u>X60X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis H.T. Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>5 yrs</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>50</u> to <u>Mar.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Mar 24</u> , 19 <u>57</u> , and that death occurred at <u>6:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James J. Means</u>				ADDRESS (Street, city or town, state) <u>5700 St. Baltimore Md</u>			
PHYSICIAN'S NAME (Type) <u>James J. Means</u>				DATE SIGNED <u>3/26/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO.</u> <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connolly</u>				ADDRESS <u>Essex 21-2nd</u>			
24a. REC'D BY REGISTRAR <u>DATE</u>				24b. REGISTRAR'S SIGNATURE <u>Danison L. Ficker</u>			

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BUREAU V. S.

MAR 10 1911

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be delivered for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

02618

CERTIFICATE OF DEATH

02609

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6156 Regent Park Rd.</b>		d. STREET ADDRESS <b>6156 Regent Park Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>T.</b> Last <b>Harrison Jr.</b>		4. DATE OF DEATH Month <b>March</b> Day <b>21</b> Year <b>1957</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 4, 1909</b>
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William T. Harrison Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Robey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs Sarah Harrison, 6156 Regent Park Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Rheumatoid Arthritis</b> <b>722.0</b> DUE TO <b>with multiple deformities &amp; Ankylosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Blindness left.</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Recurrent Bleeding Peptic Ulcer Irritabile</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1954</b> to <b>Mar. 21, 1957</b> that I last saw the deceased alive on <b>3/17/57</b> and that death occurred at <b>5:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1303 Frederick Rd</b> DATE SIGNED <b>3/21/57</b> ACTUAL SIGNATURE <b>H E Mc Grath M.D.</b> M.D. <b>Catonsville of Md</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 25/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry H. Witzke, 4101 Edmondson Ave.</b>		24a. REC'D BY REGISTRAR <b>MAR 22 '57</b> 24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	

BUREAU V. S.

1917

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02617 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02617

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sutcliffe</u>		c. LENGTH OF STAY IN 16 <u>5</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sutcliffe Md</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>511 College Ave</u>				d. STREET ADDRESS <u>1511 College Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Grason</u> First Middle Last				4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-19-1893</u>	9. AGE (In years last birthday) <u>63</u> yrs	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sutcliffe</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>P. R.</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Harvey</u>				14. MOTHER'S MAIDEN NAME <u>Sandra Pearce</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>717-07-7898</u>		17. INFORMANT <u>Carrie Smith Harvey</u> Address <u>(in)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shotgun wound throat into head</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>Sutcliffe</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Suicide</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Rollin C. Hudson</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-8-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sparks Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Sparks Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Scott Brooks</u>				24a. REGD BY REGISTRAR <u>MAR 11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MAR 12 1957

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02618

## CERTIFICATE OF DEATH

0261138

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived) II institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>301 Chesapeake Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>C.</b> Last <b>HASENKAMP</b>		4. DATE OF DEATH Month <b>Mar.</b> Day <b>11</b> , Year <b>1957</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1864</b>
9. AGE (In years last birthday) <b>92</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Paul Frederick Obrecht</b>		14. MOTHER'S MAIDEN NAME <b>Eleanore Muth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Edgar Hasenkamp - 12 Southfield Place</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial Disease</b> DUE TO <b>Ac. Congestive Cardiac Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>11 days</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>p. m.</b> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1</b> , 1957, to <b>Mar 11</b> , 1957, that I last saw the deceased alive on <b>Mar 11</b> , 1957, and that death occurred at <b>6:30</b> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Howard Warner</b> M.D.		ADDRESS (Street, city or town, state) <b>2604 Garrison Blvd.</b> DATE SIGNED <b>3/12/57</b>	
PHYSICIAN'S NAME (Type) <b>Howard Warner</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/14/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons - Balto 17 Md.</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 14 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Mabel Lutz</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 14 1957

BUREAU V. B.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02612

02619

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>44 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>H.</b> Last <b>HAUSE</b>				4. DATE OF DEATH Month <b>March</b> Day <b>31</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/22/76</b>	
9. AGE (In years last birthday) <b>81</b> yrs		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>10</b> Hours <b>0</b> Min <b>0</b>		11. IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>		12. IF UNDER 1 YEAR Months <b>1</b> Days <b>10</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JOHN HAUSE</b>				14. MOTHER'S MAIDEN NAME <b>MARY CARTER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>SAW</b>				16. SOCIAL SECURITY NO. <b>212-03-2761701</b>			
17. INFORMANT <b>An. Rec. Vets. Administration Hosp, Ft. Howard, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>493X</b> IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>GENERALIZED ARTERIOSCLEROSIS</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>February 15, 19 57</b> to <b>March 31, 19 57</b> and that death occurred at <b>10:20 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Fort Howard, Md.</b> DATE SIGNED <b>3/31/57</b> ACTUAL SIGNATURE <b>A. Polachek</b> M.D. <b>Veterans Administration Hospital</b> PHYSICIAN'S NAME (Type) <b>A. POLACHEK, M. D.</b> <b>Fort Howard, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Apr 3 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Cemetery Glen Burnie, Maryland</b>	
22d. LOCATION (City, town, or county) (State)				22e. REC'D BY REGISTRAR <b>4/1/57</b>		22f. REGISTRAR'S SIGNATURE	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Taylor Sons</b>				23a. ADDRESS <b>Annapolis, Md.</b>			

John Taylor Funeral Home, Duke of Gloucester St, Annapolis, Md.

BUREAU V. S.

APR 9 1907

RECEIVED

02620

## CERTIFICATE OF DEATH

026128

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NOTCH CLIFF-TOWSON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NOTCH CLIFF NEAR TOWSON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GLENARM Rd.</b>		d. STREET ADDRESS <b>GLENARM Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>SISTER MARY CAPITOLINA HEATH</b>		4. DATE OF DEATH Month Day Year <b>MARCH 20 1957</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 12, 1858</b>
9. AGE (In years last birthday) <b>98</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER RELIGIOUS.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTIMORE MD.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MICHAEL HEATH</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE HOLDEN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>SR. M PETER FOURIER</b>		Address <b>NOTCH CLIFF -</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BILATERAL LOBAR PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>APRIL 1952</b> to <b>MARCH 1957</b> , that I last saw the deceased alive on <b>MARCH 19, 1957</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D. ADDRESS (Street, city or town, state) <b>7501 YORK RD. TOWSON, MD.</b> DATE SIGNED <b>3/20/57</b> PHYSICIAN'S NAME (Type) <b>CHARLES F. O'DONNELL</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-22-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>VILLA MARIA CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>NOTCH CLIFF NEAR TOWSON, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Gailer</b>		24a. REC'D BY REGISTRAR <b>3/21/57</b>	
ADDRESS <b>901 S. CONKLING ST. BALTO, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel Krayer</b>	

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 26 1957

BUREAU V. S.

## 02621 CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <u>85 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>4406 - Glenmore Ave</u>		d. STREET ADDRESS <u>4406 - Glenmore Ave</u>	
3. NAME OF DECEASED (Type or print) <u>MARY M. Heck</u>		4. DATE OF DEATH <u>March 22 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1871</u>
9. AGE (In years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS, OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Myerly</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Schaefer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs Florence Finch</u>		Address <u>4406 Glenmore Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>25 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar. 20, 1957</u> , to <u>Mar. 22, 1957</u> , that I last saw the deceased alive on <u>March 20, 1957</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Adam G Swiss</u>		M.D. <u>6232 Belair Road, Balto</u>	
PHYSICIAN'S NAME (Type) <u>ADAM G. SWISS</u>		DATE SIGNED <u>Mar 22, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar. 25, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl B Wolbertson</u>		ADDRESS <u>Funeral Home, 6306 Belvoir Rd</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. A. L. Keyserling</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 20 1900

BUREAU V. S.

02622

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 CARNEY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9602 NINTH Ave</u>		d. STREET ADDRESS <u>19602 NINTH Ave</u> <input type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>G</u> Middle <u>Hobbs</u> Last		4. DATE OF DEATH <u>MARCH</u> Month <u>29</u> Day <u>1957</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 11 1892</u> 9. AGE (In years last birthday) <u>64</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONN. ARTIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sign Painter</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Hobbs</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE WEIDNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give year or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>217-14-0073</u>	
17. INFORMANT <u>Lily C Hobbs</u> Address <u>9602 NINTH Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage (Left)</u> DUE TO <u>Arteriosclerotic Cardio-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>years.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Gangrene of both legs few years ago.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> , 19 <u>57</u> , to <u>MARCH 29 1957</u> , that I last saw the deceased alive on <u>MARCH 29 1957</u> , and that death occurred at <u>7 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James E. White</u> M.D.		ADDRESS (Street, city or town, state) <u>5314 HARTFORD Rd BALTO MD</u> DATE SIGNED <u>30 March 57</u>	
PHYSICIAN'S NAME (Type) <u>JAMES E. White MD</u>		<u>BALTIMORE 14, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>April 2 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
FUNERAL DIRECTOR'S SIGNATURE <u>Chas F. Evans &amp; Son</u> ADDRESS <u>8802 HARTFORD Rd</u>		24a. REC'D BY REGISTRAR <u>APR 3 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Bacon</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 8 1967

RECEIVED

## 02623 CERTIFICATE OF DEATH

02616<sub>28</sub>

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stoneleigh</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mercy Villa, Bellona Ave</b>				d. STREET ADDRESS <b>7114 Wardman Rd.</b>			
3. NAME OF DECEASED (Type or print) <b>Eleanor</b> First <b>H</b> Middle <b>Hoene</b> Last				4. DATE OF DEATH Month <b>3</b> Day <b>2</b> Year <b>57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 29, 1873</b>	9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Sewickley, Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Frank Hunnings</b>				14. MOTHER'S MAIDEN NAME <b>Alice Patterson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Herman H. Hoene</b>		Address <b>7114 Wardman Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>1944</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>also had retroperitoneal metastatic</b> DUE TO <b>malignancy from uterine malignant</b> (c) <b>removed 10 years ago</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>1940</b> to <b>Mar 2</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Mar 2</b> , 19 <b>57</b> , and that death occurred at <b>9:50 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert B Taylor</b>				ADDRESS (Street, city or town, state) <b>700 Cathedral St Balt, Md.</b>			
DATE SIGNED <b>3-3-57</b>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/5/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Homewood</b>		22d. LOCATION (City, town, or county) (State) <b>Pittsburg, Pa.</b>	
23. BURIAL DIRECTOR'S SIGNATURE <b>Wm J. Lickens</b>				24. REG. STRAR'S SIGNATURE <b>Mabel Kays</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED U. S.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 192617  
02624 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Balto.	MARYLAND	STATE Md.	COUNTY Balto.
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Middle River	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 13 Buttercup Lane		STREET ADDRESS (If rural give location) 13 Buttercup Lane	

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) JOHN	(Middle) JOSEPH	(Last) HORLACHER	(Month) Mar. (Day) 7 (Year) 19 57
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: Feb. 13, 1884
9. AGE last birthday: 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman (rtd) Traction Co.	
11. BIRTHPLACE (State or foreign country): Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	

13. FATHER'S NAME: Frederick Horlacher		14. MOTHER'S MAIDEN NAME: Elizabeth S. Kochler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: Hughes Funeral Home Kingston, Penna.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(A) IMMEDIATE CAUSE: Cerebro-Vascular Accident		1-4 Hrs
(B) ANTECEDENT CAUSE (S): ARTERIOCLEROTIC Cerebro-Vascular Disease		5 Yrs
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Oct. 1956 to Mar 7, 1957, that I last saw the deceased alive on MAR 7, 1957, and that death occurred at 10:50 PM, from the causes and on the date stated above.

SIGNATURE: Louis J. Menoff		ADDRESS: M.D. 1437 Lincolnton, Balt 20, Md.		DATE SIGNED: 3/8/57
23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	DATE THEREOF: 3/11/57	NAME OF CEMETERY OR CREMATORY: Dennison Cem. Swoyerville, Pa.		
DATE REC'D BY LOCAL REGISTRAR: 3/8/57	REGISTRAR'S SIGNATURE: A. H. Frederick	24. FUNERAL DIRECTOR: Hughes Fun. H. Home - Kingston Pa.		

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 12 1957

BUREAU V. S.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02543

CERTIFICATE OF DEATH

02618

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6825 Holabird Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>T.</b> Last <b>HUGHES</b>				4. DATE OF DEATH Month <b>March</b> Day <b>16</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 15, 1876</b>		9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elisha Hughes</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Howard P. Hughes 2 Winona Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Infectious C. V. Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1953</b> to <b>Mar. 16</b> , 1957, that I last saw the deceased alive on <b>Mar 1</b> , 1957, and that death occurred at <b>11:40 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stephen C. Mockornish</b> M.D.				ADDRESS (Street, city or town, state) <b>6714 Holabird Ave</b>		DATE SIGNED <b>3-18-57</b>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 20, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colgate, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home 2112 Dundalk Ave.</b>				24a. REC'D BY REGISTRAR DATE <b>3/20/57</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. J. Kelly</b>	

RECEIVED

MAR 21 1957

BUREAU V. S.

## 02625 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Timber Grove Rd.</b>		d. STREET ADDRESS <b>Timber Grove Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>F.</b> Last <b>Hunter</b>		4. DATE OF DEATH Month <b>Mar.</b> Day <b>30</b> , Year <b>1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 29, 1875</b>
9. AGE (In years last birthday) <b>81 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rtd. Carpenter - self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>William R. Hunter</b>		14. MOTHER'S MAIDEN NAME <b>Ellen R. French</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Edw. H. Carrick-Timber Grove Rd., Owings Mills, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Failure - Chronic</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1954</b> , to <b>March 30, 1957</b> , that I last saw the deceased alive on <b>March 23, 1957</b> , and that death occurred at <b>7:40 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clarence E. McWilliams</b> M.D.		ADDRESS (Street, city or town, state) <b>Leicesterstown, Maryland</b>	
DATE SIGNED <b>March 30, 1957</b>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/2/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tichenor &amp; Sons - Balt. 17</b>		24a. REC'D BY REGISTRAR DATE <b>4/1/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary Elmer</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02544 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02620, 41

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore, County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN TB <b>10</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk, Maryland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1742 Grange Road</b>				d. STREET ADDRESS <b>1742 Grange Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Annie</b> First <b>Carviness</b> Middle <b>Jackson</b> Last				4. DATE OF DEATH Month <b>3</b> Day <b>24</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Daniel Jackson</b>		Address <b>1742 Grange Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>541.1</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CIRRHOSIS OF LIVER (ALCOHOL)</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> or while not at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>M B Davis</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>M B. DAVIS MD</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3--27--57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>		22d. LOCATION (City, town, or county) (State) <b>Brookling, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. O. Wilson</b>				ADDRESS <b>1000 Brantley Avenue</b>		24a. REC'D BY REGISTRAR DATE <b>3/28/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Thos. Kelly</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAR 27 1907

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02626

## CERTIFICATE OF DEATH

02621  
44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Edgemere</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6803 North Point Road</b>		e. STREET ADDRESS <b>6803 North Point Road</b>	
3. NAME OF DECEASED (Type or print) <b>MAUD</b> First <b>A.</b> Middle <b>JACKSON</b> Last		4. DATE OF DEATH <b>March 15,</b> 19 <b>57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 17, 1886</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Sinclair</b>		14. MOTHER'S MAIDEN NAME <b>Frances Rewark</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Miss Etsil Jackson</b>		Address <b>6803 North Point Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>443X Hypertensive C-V Disease</b> DUE TO <b>Chronic Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs 1 yr.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>54</b> , to <b>Jan. 15</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Mar 15</b> , 19 <b>57</b> , and that death occurred at <b>8:55 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>520 Dist Bldg 19 Md</b> DATE SIGNED <b>3/16/57</b> ACTUAL SIGNATURE <b>James T. Means</b> M.D. PHYSICIAN'S NAME (Type) <b>James T. Means</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 19, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home</b>		24a. REC'D BY REGISTRAR <b>1610</b>	
24b. REGISTRAR'S SIGNATURE <b>Dawson L. Farley</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 10 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02622

02627

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, 3401-4</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Presbyterian Home</b>				d. STREET ADDRESS <b>4505 Fernhill Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Cora</b> Middle <b>B.</b> Last <b>Jacobs</b>				4. DATE OF DEATH Month <b>March</b> Day <b>17,</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 12, 1869</b>		9. AGE (In years last birthday) <b>87</b> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Jacobs</b>				14. MOTHER'S MAIDEN NAME <b>Mary A. Cooksey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Records of Presbyterian Home Towson, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-renal-vascular disease</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b> <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 1952, to <b>March 17, 1957</b> , that I last saw the deceased alive on <b>March 7</b> , 1957, and that death occurred at <b>Md.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Rollin C. Hudson</b>				ADDRESS (Street, city or town, state) <b>606 Balto Ave Towson Md</b>		DATE SIGNED <b>3/18/57</b>	
PHYSICIAN'S NAME (Type) <b>Rollin C Hudson</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 20, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc. 1900 Eutaw Place</b>				24a. REC'D BY REGISTRAR <b>APR 20 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 20 1957

BUREAU V. B.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy must be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02623

02545 **CERTIFICATE OF DEATH**

Reg. Dist. No. 41

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>DUNDALK 22</u>		<u>45</u>		TOWN <u>DUNDALK 22</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8 CENTRE AVE.</u>				STREET ADDRESS (If rural give location) <u>8 CENTRE AVE.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>ADELIA</u> (Middle) <u>VASELINKO</u> (Last) <u>JANOWICH</u>				(Month) <u>3</u> (Day) <u>17</u> (Year) <u>57</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W.</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED,</b> <u>MARRIED</u>	<b>8. DATE OF BIRTH</b> <u>MAR 15, 1887</u>	<b>9. AGE last birthday</b> <u>70</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if (temp.)) <u>HOUSEWIFE</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>RUSSIA</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>RUSSIA</u> ✓							
<b>13. FATHER'S NAME</b> <u>VASIL VASELINKO</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>VNIK</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>218-03-8374</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>MAX JANOWICH - SAME</u>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Diabetes mellitus</u>						<u>unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>  </u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>  </u>							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>October 19, 1956</u> to <u>March 17, 1957</u> , that I last saw the deceased alive on <u>March 17, 1957</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Dr. Thomas</u>				<b>ADDRESS</b> (Street, city, town, state) <u>107 N. Main St. Balto 22 MD.</u>		<b>DATE SIGNED</b> <u>3/20/57</u>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county) (State)	
<u>Buried</u>		<u>3-21-57</u>		<u>OLAK LAWN</u>		<u>BALTO. CO. MD.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>APR 1 1957</u>		<u>Mr. Kelly</u>		<u>Robert Brock Chasely, Dundalk, Md.</u>			
<b>DATE</b>							

BUREAU OF

MAR 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02628

CERTIFICATE OF DEATH

02624

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
c. LENGTH OF STAY IN 1b <b>50 yrs.</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7404 Belair Rd.</b>				d. STREET ADDRESS <b>7404 Belair Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>J.</b> Last <b>Jasper</b>				4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 23, 1878</b>		9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sand &amp; Gravel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Ernest Herman William Jasper</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Jacobi</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-32-1631</b>		17. INFORMANT Address <b>Mrs. Henry J. Jasper 7404 Belair Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>Hypertensive Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Mar 2</b> 19 <b>57</b> , to <b>Mar 3</b> 19 <b>57</b> , that I last saw the deceased alive on <b>Mar 2</b> 19 <b>57</b> , and that death occurred at <b>4:30 p. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Max R. English</b> M.D.				ADDRESS (Street, city or town, State) <b>5713 Belair Rd Baltimore 6 Md.</b>		DATE SIGNED <b>3-4-57</b>	
PHYSICIAN'S NAME (Type) <b>Max R. English M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 7, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louise Funeral Home</b>				ADDRESS <b>7401 Belair Rd</b>		24a. REC'D BY REGISTRAR DATE <b>7 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mrs. A. L. Reynolds</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ਸਤਿਨਾਮੁ ਕਰਤਾ ਹਰਿ

Mix R. English and  
Mix R. French

[illegible]

3-4-2-4  
BUREAU V.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02625

## 02629 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

39

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u>		c. LENGTH OF STAY IN 1b <u>passing thru</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 Sparks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Piney Hill Rd.</u>			d. STREET ADDRESS <u>1 York Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Roosevelt</u> Last <u>Johnson, Jr.</u>			4. DATE OF DEATH Month <u>Mar.</u> Day <u>9</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-26-30</u>	9. AGE (in years last birthday) <u>27</u> yrs.	IF UNDER 1 YEAR Months <u>27</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>SPARKS, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Raymond Johnson</u>			14. MOTHER'S MAIDEN NAME <u>HELEN Johnson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES 2-11-52-5-1-54</u>		16. SOCIAL SECURITY NO. <u>LOST</u>		17. INFORMANT Address <u>Mrs. Evelyn Johnson, Sparks, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Crushed chest, internal injuries, suffo-</u> <u>822X</u> DUE TO <u>aspiration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile overturned &amp; deceased was crushed under car.</u>			
20c. TIME OF INJURY Hour <u>8:45</u> AM <u>PM</u> Month, Day, Year <u>3-9-1957</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Piney Hill Rd.</u>	20f. (City or town) <u>Sparks</u>	(County) <u>Balto.</u>	(State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>D. D. Corles</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>D. D. Corles, M. D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-14-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>STEVENSON A.M.E. CHURCH</u>		22d. LOCATION (City, town, or county) (State) <u>SPARKS, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Jackson, 916 Penna. Ave., Balto. 1, Md.</u>			24a. REC'D BY REGISTRAR <u>MAR 14 1957</u>		
			24b. REGISTRAR'S SIGNATURE <u>Ely. Corancho</u>		

REAR A. S.

MAR 14 1967

REAR A. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02630

CERTIFICATE OF DEATH

026261

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o STATE <u>MARYLAND</u> b COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RAIDMANSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RAIDMANSTOWN</u>	
d. NAME OF HOSPITAL (If not in hospital give street address) <u>WILKIN'S ROAD</u>		d. STREET ADDRESS <u>WILKIN'S ROAD</u>	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>HELEN</u> Last <u>KHALB</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 24 - 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEKEEPING</u>	
11. BIRTHPLACE (State or foreign country) <u>C. CALIF.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>AUGUST WEAVER</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE SPRINGER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. EDNA SCHUBERT</u>		Address <u>WILKIN'S RD - RAIDMANST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>CHRONIC EDEMA OF HEART MUSCLE</u> DUE TO (c) <u>CHRONIC CONGESTIVE HEART FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>2 YEARS</u> <u>15 YEARS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>50</u> , to <u>MARCH 26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>MARCH 26</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas E. Wheeler</u>		ADDRESS (Street, city or town, state) <u>3601 CLIFTON RD</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER</u>		DATE SIGNED <u>MARCH 26 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-29-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Randallstown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u>		24a. REC'D BY REGISTRAR <u>Dr. Hm. Martin</u>	
24b. REGISTRAR'S SIGNATURE <u>Dr. Hm. Martin</u>		DATE <u>MAR 28 1957</u>	

BUREAU V. K.

MAR 20 1957

RECEIVED

02627  
No. 77

## MEDICAL CERTIFICATION

VS. A15ME(5)  
SM 9/55

RECEIVED  
MAR 17 1957  
BUREAU V. S.

## 02632 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>2MO-1DA</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>14 SPRING GROVE STATE HOSP</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. STREET ADDRESS <b>184 ELTAN PLACE</b>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MAY ELLAN KERN</b>		4. DATE OF DEATH Month Day Year <b>3 16 1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY-20-1866</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTO-MD</b>	9. AGE (In years last birthday) <b>90</b> yrs
11. BIRTHPLACE (State or foreign country) <b>BALTO-MD</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JOHN BARRY</b>		14. MOTHER'S MAIDEN NAME <b>ALVERTA JONES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOC AL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Carrie Mitchell</b>		Address <b>410 Athol Ave</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m p. m <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **1/15**, 19**57**, to **3/16**, 19**57**, that I last saw the deceased alive on **3/16**, 19**57**, and that death occurred at **7:10 A**. M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED  
**Spring Grove State Hospital (3-18-57)**

ACTUAL SIGNATURE **Stella Wachslar** M.D. **Spring Grove State Hospital (3-18-57)**

PHYSICIAN'S NAME (Type) **STELLA WACHSLER Catonsville 28, Md.**

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/19/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Landon Park</b>	22d. LOCATION (City, town, or county) (State) <b>Balto Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Senfel</b>		ADDRESS <b>5311 Edmondson Ave</b>	24a. REC'D BY REGISTRAR DATE <b>MAR 19 57</b>
		24b. REGISTRAR'S SIGNATURE <b>W. E. Lane</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02554

## CERTIFICATE OF DEATH

02629

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE COUNTY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
c. LENGTH OF STAY IN lb <u>3 yrs</u>				x2 <u>BALTIMORE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2721 ALDERWOOD AVE</u>				d. STREET ADDRESS <u>2721 ALDERWOOD AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARA A. KIRBY</u>				4. DATE OF DEATH Month Day Year <u>MARCH 5 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 19, 1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR DRESS MFR.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Geo Fred STOLL</u>		14. MOTHER'S MAIDEN NAME <u>BARBARA WAMBACH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-09-5944</u>		17. INFORMANT <u>MRS. THOMAS F. GARVEY</u>		Address <u>2721 ALDERWOOD AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Generalized Arteriosclerotic C.V.D. - 10 years</u> DUE TO (c) <u>Generalized Arteriosclerotic C.V.D. - 10 years</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>56</u> , to <u>Mar</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Mar 4</u> , 19 <u>57</u> , and that death occurred at <u>4 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2721 Alderwood Ave</u> DATE SIGNED <u>3/7/57</u>							
ACTUAL SIGNATURE <u>Paul Schinfeld</u> M.D.				PHYSICIAN'S NAME (Type) <u>PAUL SCHINFELD M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>MARCH 8, 1957</u>		<u>NEW CATHEDRAL</u>		<u>BALTO. MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Truman Schwalb</u>				ADDRESS <u>3512 Frederick Ave.</u>		24a. REC'D BY REGISTRAR <u>Mr. Geo M. Kueffer</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mr. Geo M. Kueffer</u>			

3512 Frederick Ave. (29)

MARCH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 9 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**02633 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**02630**

Reg. Dist. No. **45**

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>811 ESSEX AVE.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>KNIGHT</b> Last <b>KNIGHT</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>17</b> Year <b>1957</b>		5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 4 1907</b>		9. AGE (In years last birthday) <b>50</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CRANE OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AIR CRAFT</b>	
13. FATHER'S NAME <b>JAMES J. KNIGHT</b>				14. MOTHER'S MAIDEN NAME <b>MARY E. DASCH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-07-4236</b>		17. INFORMANT <b>THEKESA KNIGHT</b>		Address <b>SAME</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypertensive C-V. Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>M.B. Davis MD</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>M.B. DAVIS MD</b>		DATE SIGNED <b>3/17/57</b>					
22a. REMOVAL, CREMATION, BURIAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-20-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT. CARMEL</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. B. Buggs</b>				ADDRESS <b>1407 EASTER AVE</b>		24a. REC'D BY REGISTRAR DATE <b>3/18/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Edith H. H. H.</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU T. O.

MAR 2 1971

RECEIVED

## 02555 CERTIFICATE OF DEATH

Reg. Dist. No.

47

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u>				c. LENGTH OF STAY IN 1b <u>2 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2114 Gaylawn Drive</u>				e. STREET ADDRESS <u>2114 Gaylawn Drive</u>			
3. NAME OF DECEASED (Type or print) <u>Rose M. Koerner</u>				4. DATE OF DEATH Month <u>3</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/9/1890</u>	9. AGE (In years last birthday) <u>66</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Michael Zinkand</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <u>  </u>			
16. SOCIAL SECURITY NO <u>  </u>				17. INFORMANT <u>Mr. Edward T. Koerner</u> Address <u>2114 Gaylawn Drive</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage, right with left</u> <u>443X</u> DUE TO <u>Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic hypertensive CVD</u> DUE TO <u>  </u> (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>57</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>				20g. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>			
21. I certify that I attended the deceased from <u>March 19, 1957</u> to <u>March 23, 1957</u> that I last saw the deceased alive on <u>March 23, 1957</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Herbert J. Levickas</u> M.D. <u>5305 East Drive</u>				DATE SIGNED <u>3/23/57</u>			
PHYSICIAN'S NAME (Type) <u>Herbert J. Levickas</u> <u>Baltimore - 27, Md.</u>				22a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>Dr. Geo M. Kuffner</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>4300 Old Frederick Rd.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan &amp; Son</u> ADDRESS <u>901 Hollins St.</u>				24a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>  </u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
MAR 26 1957  
NAVY U. S.

## 02634 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Catonville Balto Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Baltimore City</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>				c. LENGTH OF STAY IN 1b <u>2 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The House Of Pines Nursing Home</u>				d. STREET ADDRESS <u>1711 De Sota Rd. 3V014</u> v			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Mathilda</u>		First Middle Last <u>Kolberg</u>		4. DATE OF DEATH Month <u>3</u> Day <u>17</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9 -15 - 1877 ?</u>	9. AGE (In years last birthday) <u>80 ?</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hosewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Germany</u>		11. BIRTHPLACE (State or foreign country) <u>U S A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Scholz</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO <u>214-03-2808</u>		17. INFORMANT Address <u>Irvin A Vogel 1711 De Sota Rd Balto 30 Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Paralysis Agitans</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL 28, 1947</u> to <u>MARCH 17, 1957</u> , that I last saw the deceased alive on <u>FEB 27, 1957</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Arthur Rossberg M.D.</u>		ADDRESS (Street, city or town, state) <u>2436 Washington Blvd Baltimore 30, Md.</u>				DATE SIGNED <u>3/18/57</u>	
PHYSICIAN'S NAME (Type) <u>C. ARTHUR ROSSBERG M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-20- 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Wash Blvd Howard Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Toulson 2359 Wash Blvd Balto 30 Md</u>				24a. REC'D BY REGISTRAR <u>W. J. Smith</u>		24b. REGISTRAR'S SIGNATURE	
				DATE <u>MAR 20 '57</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

MAR 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02556

CERTIFICATE OF DEATH

02633

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>	
c. LENGTH OF STAY in 1b <b>30 yrs.</b>		d. STREET ADDRESS <b>1335 Birch Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1335 Birch Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Juliana Kraemer</b>		4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 1, 1860</b>
9. AGE (In years last birthday) <b>96</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>Germany</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Julia Diener</b>		Address <b>1335 Birch Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Insufficiency</b> <b>199.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Age -</b> (c) <b>Cancer</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> <b>3 years 3 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4-25, 1955</b> , to <b>3-13, 1957</b> , that I last saw the deceased alive on <b>3-6, 1957</b> , and that death occurred at <b>5 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. B. Daugherty</b> M.D.		ADDRESS (Street, city or town, state) <b>1264 Francis Ave. Baltimore - 27, Md.</b>	
PHYSICIAN'S NAME (Type) <b>A. B. Daugherty</b>		DATE SIGNED <b>3/14/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>March 16, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ambrose, Inc. 1328 Sulphur Spring Rd.</b>		24a. REC'D BY REGISTRAR <b>Dr. G. M. Kieffer</b>	

RECEIVED

MAR 18 1957

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02557

## CERTIFICATE OF DEATH

Reg. Dist. No.

02634

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ARBUTUS</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 ARBUTUS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4201 Fordham Rd</b>				d. STREET ADDRESS <b>4201 Fordham Rd</b>			
3. NAME OF DECEASED (Type or print) <b>CLAUDE C LANMAN</b> First Middle Last				4. DATE OF DEATH <b>March 5, 1957</b> Month Day Year			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 30, 1884</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired President</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Novelty Steam Wks. Monticello, Ill</b>			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY			
13. FATHER'S NAME <b>GEORGE W LANMAN</b>				14. MOTHER'S MAIDEN NAME <b>JENNIE BUCHANAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>215-09-4973</b>			
17. INFORMANT <b>Nelle B. Lanman</b> Address <b>4201 Fordham Rd</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4201</b> DUE TO <b>Myocardial Infarction with hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arterio-sclerosis</b> DUE TO (c) <b>arterio-sclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1957</b> <b>1957</b> <b>1952</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>March 1952</b> to <b>March 5, 1957</b> that I last saw the deceased alive on <b>Feb 25, 1957</b> and that death occurred at <b>10:24</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>William S. Farnson</b> M.D. PHYSICIAN'S NAME (Type) <b>William S. Farnson</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>2-8-57</b>		<b>Lorraine Park</b>		<b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b> ADDRESS <b>4107 Wilkens Ave</b>				24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Geo M. Jeffers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

1937

1937

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02635

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived (If institution: Residence before admission)) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>359 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Milton</u> <u>NMI</u> <u>Lawrence</u>				4. DATE OF DEATH Month Day Year <u>March</u> <u>16</u> <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/1/74</u>	
9. AGE (In years last birthday) <u>82</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coast Guard</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George I. Lawrence</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Jordan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Clin. Rec. Vets Admin. Hospital, Ft. Howard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF PALATE</u> <u>144X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that <u>1747</u> attended the deceased from <u>March 22</u> , 19 <u>56</u> , to <u>March 16</u> , 19 <u>57</u> , that <u>the deceased</u> <u>died</u> <u>on</u> <u>March 16, 1957</u> , and that death occurred at <u>11:25 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Veterans Administration Hospital</u> <u>3/16/57</u>							
ACTUAL SIGNATURE <u>J. A. Baranowski M.D.</u> M.D. <u>Veterans Administration Hospital</u> <u>3/16/57</u>							
PHYSICIAN'S NAME (Type) <u>J. A. BARANOWSKI M.D.</u> <u>Fort Howard, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-20-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook - Blight Inc.</u> ADDRESS <u>WM. COOK-BLIGHT, INC., 6009 Harford Road, Balto., Md.</u>				24a. REC'D BY REGISTRAR <u>181055</u>		24b. REGISTRAR'S SIGNATURE <u>L. Farley</u>	

BUREAU V. S.

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CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Balto - Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hanover</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson Md</u>		c. LENGTH OF STAY IN 1b <u>1 Week</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson General Hospital Home</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bell Air Road</u>	
		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Mary G. Lawson</u> First Middle Last		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 21 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 Hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>social worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Leominster Ma</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Robert L. Lawson</u>		14. MOTHER'S MAIDEN NAME <u>Bethie Cohen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Marie Kuleski</u> Address <u>Mar Paul Rd Bell Air Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Haemorrhage</u> <u>351X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension - Arterio-Sclerotic</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/2</u> 1957, to <u>May 5</u> 1957, that I last saw the deceased alive on <u>May 5</u> 1957, and that death occurred at <u>12 M</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter A. Baetjer</u> M.D.		ADDRESS (Street, city or town, state) <u>1101 St Paul St</u> DATE SIGNED <u>May 5</u>	
PHYSICIAN'S NAME (Type) <u>WALTER A. BAETJER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 7/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hollywood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Richmond Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. Smith</u> ADDRESS <u>Bell Air Road</u>		24a. REC'D BY REGISTRAR <u>May 7 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>

BUREAU V. S.

1957

10-15-57

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**02637 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02637

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u>			c. LENGTH OF STAY IN 1b <u>2 yrs</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BEAVER DAM &amp; COCKEYSVILLE RDS</u>				d. STREET ADDRESS <u>BEAVER DAM &amp; COCKEYSVILLE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry Lee</u>				4. DATE OF DEATH Probably Month Day Year <u>March 24 1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 2, 1885</u>	
				9. AGE (In years last birthday) <u>72 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARETAKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>PARK</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>GEO. LEE</u>				14. MOTHER'S MAIDEN NAME <u>MAMIE ROBINSON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Raymond Lee Towson, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>  <u>440.1</u> DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }  DUE TO (b)  DUE TO (c) </p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION</u>		22d. LOCATION (City, town, or county) (State) <u>KING GREEN BALTO., CO., MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Am. Schatman</u> ADDRESS <u>1701 McCall St. Balt., Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 3-28-57</u>		24b. REGISTRAR'S SIGNATURE <u>Aut. Seal</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02638

## CERTIFICATE OF DEATH

02638

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pampstead</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>Route 1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LEWIS F. LEPP</u>				4. DATE OF DEATH Month Day Year <u>March 3 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 7, 1874</u>	9. AGE (In years lost birthday) <u>82</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Machine Shop</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Emanuel Leppo</u>				14. MOTHER'S MAIDEN NAME <u>Carrie (Maiden Name Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>Spanish American Unknown</u>		17. INFORMANT Address <u>Clin. Pec., Vet. Administration Hosp. Ft. Howard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA BILATERAL</u> <u>163</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA UPPER AND LOWER LEFT LOBES OF LUNG</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>December 18, 1956</u> , to <u>March 3</u> , 19 <u>57</u> . That I am a duly licensed physician and that death occurred at <u>5:25 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Roland D. Ponce de Leon</u> M.D.				ADDRESS (Street, city or town, state) <u>VAH, Fort Howard, Md.</u>		DATE SIGNED <u>3/3/57</u>	
PHYSICIAN'S NAME (Type) <u>ROLAND D. PONCE DE LEON, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 6-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Wesley Chapel, Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Tipton Funeral Home, Pampstead, Md.</u>			24a. REC'D BY REGISTRAR <u>Mar 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Taylor</u>		

BUREAU V. S.

MAR 2

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

02639

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02639

Reg. Dist. No. 35

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks.</u>	c. LENGTH OF STAY IN 1b <u>51 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>York Rd.</u>		d. STREET ADDRESS <u>York Rd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles E. Lloyd</u>		4. DATE OF DEATH Month Day Year <u>March 27 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16 1883</u>
9. AGE (In years) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assembler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Box Factory Balto. Co., Md</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. Lloyd</u>		14. MOTHER'S MAIDEN NAME <u>Laura Bull.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-32-9471</u>	
17. INFORMANT <u>Harry C. Lloyd</u>		Address <u>2343 York Rd., Timonium, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> DUE TO (c) <u>2 Days</u> INTERVAL BETWEEN ONSET AND DEATH PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		DATE SIGNED <u>3-28-57</u>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 29 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Maryland Line Cem. Maryland Line, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Maryland Line, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Fortenstein</u>		24a. REC'D BY REGISTRAR <u>3/30/57</u>	
ADDRESS <u>New Freedom, Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles F. O'Donnell</u>	

BUREAU V. S.

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02640

## CERTIFICATE OF DEATH

02640

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>Route #3</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Pauline Amanta Hauck Lockwood</u>		4. DATE OF DEATH Month Day Year <u>3 - 22 - 19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 14, 1895</u>
9. AGE (In years last birthday) <u>62</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>August Hauck</u>		14. MOTHER'S MAIDEN NAME <u>Kathie Meier</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction; hypertension</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary atherosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 18, 1957</u> , to <u>3-22-1957</u> , that I last saw the deceased alive on <u>3-22-1957</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>David E. Edwards</u> M.D.		SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) <u>DAVID E. EDWARDS</u>		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3/26/57</u>	<u>Baltimore National</u>	<u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward J. Kirk</u>		ADDRESS <u>5305 Harford</u>	
24a. REC'D BY REGISTRAR <u>Mar 26 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is to be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
MAR 26 1957  
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending," in pencil in Item 18. Give Pages 1-2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM-3. Page 4 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

1  
02641 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02641  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>				c. LENGTH OF STAY IN 1b <b>10 YRS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>919 LUTZ AVE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Joseph Anthony Lukosewich</b> First Middle Last				4. DATE OF DEATH <b>March 7 19 57</b> Month Day Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 1884</b>	
9. AGE (In years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Cloth. Mfg</b>		11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Lithuania</b>							
13. FATHER'S NAME <b>Frank Lukosewich</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>215-035607</b>		17. INFORMANT <b>URSULA LUCAS</b> Address <b>919 Lutz Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A-S-C-V-Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>M B Davis</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>M B DAVIS MD</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-11-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George L Schwab</b> ADDRESS <b>2101 Frederick</b>				24. REC'D BY REGISTRAR <b>Edith L. Lipp</b> DATE <b>3/11/57</b>			

DATE SIGNED  
**3/11/57**

BUREAU V. B.

MAR 11 1957

RECEIVED

02642

## CERTIFICATE OF DEATH

02642

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>5 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. STREET ADDRESS <b>824 N. Durham Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>M.</b> Last <b>MAJOR</b>		4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 13, 1896</b>
9. AGE (In years last birthday) yrs. <b>60</b>		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shipyard</b>	
11. BIRTHPLACE (State or foreign country) <b>Lanes, South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Sam Major</b>		14. MOTHER'S MAIDEN NAME <b>Lizzie Bradshaw</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>215-09-6399</b>	
17. INFORMANT <b>Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: (a) <b>ACUTE PULMONARY EDEMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 20, 1957</b> , to <b>March 25, 1957</b> , and that death occurred at <b>5:40 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>3/25/57</b>			
ACTUAL SIGNATURE <b>Edmund A. Foster</b>		M.D. <b>VAH, FORT HOWARD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>EDMUND A. FOSTER, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/29/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert Elliott</b>		24a. REC'D BY REGISTRAR <b>3/26/57</b>	
ADDRESS <b>1129 N. Caroline Street, Baltimore, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Harber</b>	

Robert Elliott Funeral Home, 1129 N. Caroline Street, Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02643

02643 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY IN 1b <u>1 yr.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>34 Featherbed Lane</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u> Md. </u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> d. STREET ADDRESS <u>34 Featherbed Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John H. Manchey</u> First Middle Last		4. DATE OF DEATH <u>March 4,</u> 19 <u>57</u> Month Day Year	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12, 1898</u>
9. AGE (In years last birthday) <u>58</u> yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Valentine Manchey</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>219-03-6143</u>	
17. INFORMANT <u>Viola M. Manchey</u>		Address <u>Owings Mills, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Angina Pectoris</u> <u>44-0-2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> 19 <u>57</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>
20f. (City or town) <u>none</u>		(County) (State)	
21. I certify that I attended the deceased from <u>3-31-52</u> , 19 <u>52</u> to <u>3-4-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-1-57</u> , 19 <u>57</u> , and that death occurred at <u>8:45 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6 Hanover Road</u> DATE SIGNED <u>3-5-57</u> ACTUAL SIGNATURE <u>D. D. Caples</u> M.D. NAME (Type) <u>D. D. Caples, M. D.</u> <u>Reisterstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/7/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Manchester Cemetery</u>
22d. LOCATION (City, town, or county) <u>Manchester, Maryland</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline and Sons</u>		ADDRESS <u>Reisterstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>3-7-57</u>		DATE <u>3-7-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ESTABLISHED

1871

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02644 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02644

Reg. Dist. No. 45

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore County</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>TURKEY POINT Rd. Sue. Cwp.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX 21</u> d. STREET ADDRESS <u>TURKEY POINT Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) <u>Herbert Austin Mathisen</u>		<b>4. DATE OF DEATH</b> Month <u>3</u> - Day <u>2</u> - Year <u>1957</u>		<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>5-27-24</u>		<b>9. AGE</b> (In years last birthday) <u>32</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min
IF UNDER 1 YEAR		IF UNDER 24 HRS.																	
Months	Days	Hours	Min																
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>ENG.</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>AIRCRAFT.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>NY</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA.</u>											
<b>13. FATHER'S NAME</b> <u>ARTHUR MATHISEN</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>PAULINE BERGENDALH.</u>															
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u>		<b>16. SOCIAL SECURITY NO.</b> <u>102-15-443</u>		<b>17. INFORMANT</b> <u>Emily Mathisen</u>		<b>Address</b> <u>16 ASTER AVE. Ld. NY</u>													
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bacterial Meningitis</u> DUE TO <u>116X</u> Conditions, if any, which gave rise to immediate cause (b) <u>Infection of Skin graft of Left Eye</u> (c) <u>Infraction of Skin graft of Left Eye</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2.23</u>								<b>INTERVAL BETWEEN ONSET AND DEATH</b>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)															
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> a. m. p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>													
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																			
<b>ACTUAL SIGNATURE</b> <u>William V. [Signature]</u>				<b>M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/></b> <b>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/></b> <b>DEPUTY MEDICAL EXAMINER <input type="checkbox"/></b>															
<b>EXAMINER'S NAME (Type)</b>				<b>DATE SIGNED</b> <u>3-2-57</u>															
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u>		<b>22b. DATE THEREOF</b> <u>3-3-1957</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Maple Grove Cemetery, Jamaica Ld. NY.</u>		<b>22d. LOCATION, (City, town, or country) (State)</b>													
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>James [Signature]</u>				<b>24a. REC'D BY REGISTRAR</b> <u>3/3/57</u>															
<b>ADDRESS</b> <u>1407 Eastern Cwp</u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Eric Hurley</u>															

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02645

## CERTIFICATE OF DEATH

02645

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto. Co. MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <u>STARYLAND</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN life <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Douglas Memorial Home</u>				d. STREET ADDRESS <u>12 Shipley Ave.</u>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>Matthews</u> Last <u>Matthews</u>				4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>57</u> <u>19</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 16, 1877</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Howard Co., Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>John Harris</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Fuller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Olevia Tubman 1318 E. Stockton Street.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mitral Insufficiency</u> <u>46.00</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO (c) <u>?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>I yr. 6 Mo. 7 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9/10/55</u> , 19 <u>55</u> , to <u>3/15/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/15/57</u> , 19 <u>57</u> , and that death occurred at <u>11.30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>57 Winters Lane, Catonsville</u> DATE SIGNED <u>3/15/57</u> ACTUAL SIGNATURE <u>C. F. Maloney</u> PHYSICIAN'S NAME (Type) <u>C. F. Maloney, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-18-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William A. Jackson Funeral Home Inc.</u>				24a. REC'D BY REGISTRAR <u>MAR 20 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Jackson</u>	

916 Pennsylvania Ave. Balto. 1, Md.

RECEIVED

MAR 24 1957

BUREAU V. 3

02646

CERTIFICATE OF DEATH

02646

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baets Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Md</u> b. COUNTY <u>Baets Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catozsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catozsville Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>613 Beaumont</u>		d. STREET ADDRESS <u>613 Beaumont ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Walter</u> Last <u>Walter</u>		4. DATE OF DEATH Month <u>3</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/16/92</u>
9. AGE (In years, last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wire Chain Mfg</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward J. Walter</u>		14. MOTHER'S MAIDEN NAME <u>Helen Wordman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>Mrs Anna Mayberry</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> DUE TO <u>with Metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/1 - 1957</u> to <u>3/7 - 1957</u> , that I last saw the deceased alive on <u>3/6 - 1957</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles A. Cahn</u> M.D.		ADDRESS (Street, city or town, state) <u>2145 W. Baltimore St Baltimore Md</u>	
PHYSICIAN'S NAME (Type) <u>Charles A. Cahn</u>		DATE SIGNED <u>Mar 11 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/9/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forrester</u>	22d. LOCATION (City, town, or county) (State) <u>Baets Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Hall &amp; Son</u>		ADDRESS <u></u>	
24a. RECEIVED BY REGISTRAR <u>Mar 11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Hall</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 11 1957

RECEIVED

02647

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Center</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>				c. LENGTH OF STAY IN 1b <u>3 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1216 Shore Rd.</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Phoebe</u> Last <u>McCauley</u>				4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-26-1873</u>	9. AGE (In years last birthday) yrs <u>84</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edwin Lot Bergstreser</u>				14. MOTHER'S MAIDEN NAME <u>Ceciela Callahan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>John B. McCauley 1216 Shore Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4:30.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO (c) <u>14R</u> <u>10YRS</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 1</u> 19 <u>57</u> , to <u>Mar 1</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Mar 1</u> 19 <u>57</u> , and that death occurred at <u>9:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis Semenov</u> M.D.				ADDRESS (Street, city or town, state) <u>1437 F. Wayland Ave</u> DATE SIGNED <u>3/1/57</u>			
PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOFF</u>				<u>Balto 2.0</u> , Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>3-1-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hublersburg</u>		22d. LOCATION (City, town, or county) (State) <u>Hublersburg, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Bruzdinski</u>				ADDRESS <u>1407 Eastern Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>3/1/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 5 19

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>V</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>105 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				e. STREET ADDRESS <b>500 East 42nd Street</b>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>J.</b> Last <b>McGRATH</b>				4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 30, 1882</b>	9. AGE (In years last birthday) <b>74</b> yrs	IF UNDER 1 YEAR Months <b>7</b> Days <b>4</b> Hours <b>1</b> Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stationary Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School Building</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Patrick McGrath</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Butler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Clinical Records, Vet. Adm. Hosp., Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF THE RECTUM WITH GENERALIZED METASTASIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>420.0</b> (b) <b>PARAPLEGIA BELOW T4 SECONDARY TO NO. 1</b> DUE TO (c) <b>3 MONTHS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>7 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease. Laminectomy T3 T4 T5 removal of extra-dural tumor (partially)</b>						19. WAS AUTOPSY PERFORMED? <b>NO</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 16, 1956</b> , to <b>March 1, 1957</b> , and that death occurred at <b>8:25 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>3/1/57</b>							
ACTUAL SIGNATURE <b>Joseph M. Miller</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b>							
PHYSICIAN'S NAME (Type) <b>JOSEPH M. MILLER, M.D., Chief, Surgical Service, VAH, FORT HOWARD, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 4, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Moran Funeral Home, 3000 E. Baltimore Street</b>				24a. REG'D BY REGISTRAR <b>5 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Damon L. Farley</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02649

CERTIFICATE OF DEATH

02649

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Belt. City 3rd 4</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SPRING GROVE STATE HOSPITAL</i>		d. STREET ADDRESS <i>3915 Fairview Ave.</i>	
3. NAME OF DECEASED (Type or print) First <i>Sadie</i> Middle <i>Pettit</i> Last <i>Medcalf</i>		4. DATE OF DEATH Month <i>March</i> Day <i>13</i> Year <i>1957</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>December 19, 1880</i>
9. AGE (In years last birthday) <i>76 yrs</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Franklin Pettit</i>		14. MOTHER'S MAIDEN NAME <i>Emma Poulthney</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>UNKNOWN</i>	
17. INFORMANT Address <i>Records: SPRING GROVE STATE HOSPITAL</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>422.1</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Senility</i>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Nov 9</i> 19 <i>56</i> , to <i>March 13</i> 19 <i>57</i> , that I last saw the deceased alive on <i>March 13</i> 19 <i>57</i> , and that death occurred at <i>10:15 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Stella Wachsler</i>		ADDRESS (Street, city or town, state) <i>SPRING GROVE STATE HOSPITAL</i> DATE SIGNED <i>3-14-57</i>	
PHYSICIAN'S NAME (Type) <i>Stella Wachsler, M.D.</i>		<i>Catonsville 28, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/16/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Woodlawn, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. J. Tietener</i>		24a. REC'D BY REGISTRAR <i>17</i> ADDRESS <i>17</i>	
		24b. REGISTRAR'S SIGNATURE <i>Reich</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director; page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 18 1957

BUREAU V. S.

## 02558 CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) STATE <b>Maryland</b> COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5632 Oakland Rd.</b>				d. STREET ADDRESS <b>5632 Oakland Rd.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>E.</b> Last <b>Meekins</b>				4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>July 14, 1885</b>	
9. AGE (In years last birthday) <b>70</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Maryland</b>							
13. FATHER'S NAME <b>Francis Ellwoor</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ward</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>None</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Mrs. Anne Mack</b>				Address <b>5632 Oakland Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia, Cancerous</b> DUE TO (b) <b>Sarcoma, Metastatic Abdomen</b> DUE TO (c) <b>Sarcoma Rt Breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b> <b>9 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Sept 4, 1952</b> to <b>March 25, 1957</b> , that I last saw the deceased alive on <b>3-25, 1957</b> , and that death occurred at <b>8:20 M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>1264 Francis Avenue, Baltimore, Md.</b>							
DATE SIGNED <b>3-25-57</b>							
ACTUAL SIGNATURE <b>A. Bradley Daugharthy</b> M.D. <b>1264 Francis Avenue</b>							
PHYSICIAN'S NAME (Type) <b>A. Bradley Daugharthy M. D.</b> <b>1264 Francis Avenue, Baltimore 27, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 26, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ambrice, Inc. 1325 Delfield Spring Rd.</b>				24a. REC'D BY REGISTRAR <b>DATE 27 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Geo M. Kueffer</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
MAR 27 1957  
BUREAU V. S.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02651

02650 **CERTIFICATE OF DEATH**

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>BALTIMORE</i>		MARYLAND		STATE <i>MARYLAND</i>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		LENGTH OF STAY (in this place) <i>7 weeks</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>BALTIMORE</i>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>SHADY NOOK HOME</i>				STREET ADDRESS (If rural give location) <i>248 S. Louden Ave.</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>HARRY</i> (First) <i>MEETH</i> (Middle) <i>SR.</i> (Last)				<b>4. DATE OF DEATH</b> (Month) <i>MARCH</i> (Day) <i>19</i> (Year) <i>1957</i>			
<b>5. SEX</b> <i>Male</i>	<b>6. COLOR OR RACE</b> <i>White</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>MARRIED</i>	<b>8. DATE OF BIRTH</b> <i>Sept. 3, 1874</i>	<b>9. AGE last birthday</b> <i>82</i> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>BUTCHER</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>SELF EMP.</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>BALTO-MARYLAND</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>	
<b>13. FATHER'S NAME</b> <i>HENRY MEETH</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>CATHERINE TRIBBE</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <i>—</i>		<b>17. INFORMANT &amp; ADDRESS</b> <i>MEETH Mrs. WILHELMINA E. FLANDER</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>1422.1 IMMEDIATE CAUSE (A)</b> <i>Cardiovascular Collapse</i>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>1 Week</i>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <i>Arteriosclerosis</i>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work		<b>21e. INJURY OCCURRED</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <i>9/1</i> <i>56</i> to <i>9/19</i> <i>59</i>, that I last saw the deceased alive on <i>3/19/59</i>, and that death occurred at <i>11:00 A.M.</i> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>D. H. Tedwick</i>				<b>ADDRESS</b> (Street, city, town, state) <i>3336 Furber St. Baltimore, Md. 21214</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>		<b>DATE THEREOF</b> <i>3/21/57</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>Louden Park Cem.</i>		<b>LOCATION</b> (City, town, or county) (State) <i>Baltimore Maryland</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>D. H. Tedwick</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>S. T. Tuman</i>		<b>ADDRESS</b> <i>Schwal</i>	
<b>DATE</b> <i>MAR 21 1957</i>							

BUREAU V. S.

MAR 21 1957

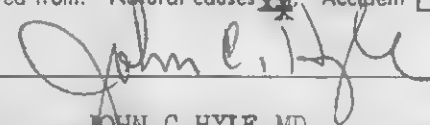

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02651 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02652  
38

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> <span style="float: right;">b. COUNTY <u>Balto</u></span>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural--Balto</u>			c. LENGTH OF STAY IN 1b <u>30yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Balto</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2801 Linganore, Balto 14</u>				d. STREET ADDRESS <u>2801 Linganore, Balto 14</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Frank</u> Middle <u>M</u> Last <u>Metzler</u>				<b>4. DATE OF DEATH</b> Month <u>Mar</u> Day <u>19</u> Year <u>19 57</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>26 Aug 1898</u>		
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>Art Painting Corp</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>John Metzler</u>				14. MOTHER'S MAIDEN NAME <u>Heneretta Piernstein</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-09-8883</u>		17. INFORMANT Address <u>Josephine Metzler 2801 Linganor Ave</u>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Coronary Artery Disease</u> DUE TO (c) <u>or assoc with Hypertensive Cardiovascular Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Inst</u>  <u>undet</u>  <u>undet</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE 				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-19-57</u>		
EXAMINER'S NAME (Type) <u>JOHN C HYLE MD</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 22 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Taylor Avenue Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Dippel Brothers 7110 Belair Road Balto 6 Md</u>				24a. REC'D BY REGISTRAR <u>DATE 3 22 1957</u>		24b. REGISTRAR'S SIGNATURE 		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

U.S. DEPARTMENT OF JUSTICE

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>				c. LENGTH OF STAY IN 1b <b>32 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 2V01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>				d. STREET ADDRESS <b>249 Exeter Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>--</b> Last <b>MILLENSON</b>				4. DATE OF DEATH Month <b>3</b> Day <b>30</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/22/17</b>	
9. AGE (In years last birthday) <b>40</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lewis Millenson</b>				14. MOTHER'S MAIDEN NAME <b>Mary Garner Weiner Millenson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>Rosewood records Owings Mills, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Epileptic convulsion</b> DUE TO (c) <b>Mongolism</b>							INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>May</b> , 19 <b>57</b> , to <b>Mar 30</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>March 30th</b> , 19 <b>57</b> , and that death occurred at <b>4:55p M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rosewood State Training Sch.</b> DATE SIGNED <b>3/30/57</b>							
ACTUAL SIGNATURE <b>Viola B. Johns</b>		PHYSICIAN'S NAME (Type) <b>Viola B. Johns</b> <b>Rosewood State Training School</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-1-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rosedale</b>		22d. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis Jr</b>				ADDRESS <b>2100 Exeter Rd</b>		24a. REC'D BY REGISTRAR <b>APR 2 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary Elie</b>			

BUREAU V. S.

APR 1963

RECEIVED  
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02653

## CERTIFICATE OF DEATH

Reg. Dist. No. 39

Iter. 9 Filed 3-26-57 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Monkton</u>		LENGTH OF STAY (In this place) <u>28 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Monkton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Monkton Rd</u>				STREET ADDRESS (If rural give location) <u>Monkton Rd</u>			
3. NAME OF DECEASED (Type or Print) <u>Clarence Edward Miller</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 15 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>5 August 1898</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRR</u>		11. BIRTHPLACE (State or foreign country) <u>Heretford Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clarence B Miller</u>				14. MOTHER'S MAIDEN NAME <u>Dora Naylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>717-07-8829</u>		17. INFORMANT & ADDRESS <u>Wife - Same</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cancer of Bladder</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>August 1948</u> to <u>March 1957</u> , that I last saw the deceased alive on <u>14 March 1957</u> , and that death occurred at <u>5:15</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Walter T. Keen</u>				DATE SIGNED <u>15 March 1957</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>MAR. 18, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Heretford Baptist Cem.</u>		LOCATION (City, town, or county) (State) <u>Heretford, Md.</u>	
24. REC'D BY REGISTRAR <u>Walter T. Keen</u>		REGISTRAR'S SIGNATURE <u>Walter T. Keen</u>		FURNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Md.</u>		ADDRESS <u>Towson, Md.</u>	

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

1957

RECEIVED

## 02654 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 Monkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MANOR RD.</u>		d. STREET ADDRESS <u>'MANOR RD.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES ELLISON MILLER</u>		4. DATE OF DEATH Month Day Year <u>3 23 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-2-1893</u>
9. AGE (in years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM HAND</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALFRED JAMES MILLER</u>		14. MOTHER'S MAIDEN NAME <u>CHARLOTTE ANN HALL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES W.W.I.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>THEL MARIE MILLER</u>		Address <u>MONKTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>adenocarcinoma of Rectum - metastases</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic heart disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> 19 <u>53</u> , to <u>March</u> 19 <u>57</u> , that I last saw the deceased alive on <u>22 March</u> 19 <u>57</u> , and that death occurred at <u>2 A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter T. Kees</u>		DATE SIGNED <u>3-23-57</u>	
PHYSICIAN'S NAME (Type) <u>Walter T. Kees</u>		ADDRESS (Street, city or town, state) <u>Cockeysville Md</u>	
22a. BURIAL, CREMATION, or other disposal of body <u>3/27/57</u>		22b. DATE THEREOF <u>3/27/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>mt. joy</u>		22d. LOCATION (City, town, or county) (State) <u>Monkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. L. Chatman</u>		24a. REC'D BY REGISTRAR <u>26157</u>	
ADDRESS <u>1701 Mt. Calhoun St. Balto. Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. G. ...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 5 1957

RECEIVED  
MAR 5 1957

## MARYLAND STATE DEPARTMENT OF HEALTH

02656

2411 N. Charles Street, Baltimore

02655

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

Item 9 Film 3-19-57 et

1. PLACE OF DEATH COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MARYLAND</b> COUNTY <b>BALTIMORE</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>ROGERS FORGE</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>ROGERS FORGE - BALTA 12</b>	
TOWN <b>ROGERS FORGE</b>		TOWN <b>ROGERS FORGE - BALTA 12</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>7014 HEATHFIELD ROAD</b>		STREET ADDRESS (If rural, give location) <b>7014 HEATHFIELD ROAD</b>	
3. NAME OF DECEASED (Type or Print) <b>WILLIAM DEVIN MINTER</b>		4. DATE OF DEATH <b>MARCH 9 1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>AUGUST 30, 1927</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHIPPING SUPT. - RET.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL FABRICATION</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES LETHRIDGE MINTER</b>		14. MOTHER'S MAIDEN NAME <b>FANNIE WILEY DEVIN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY No. <b>416-07-7158</b>	
17. INFORMANT <b>FAMILY RECORDS</b>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <b>OCCCLUSION OF CORONARY ARTERY</b>		<b>10 min.</b>	
Antecedent cause(s) (b) <b>ARTERIOSCLEROSIS, General - Central</b>		<b>10 years</b>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <b>NONE</b>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE <b>NONE</b>		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>m.</b>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Dec 4**, 19**54**, to **March 9**, 19**57**, that I last saw the deceased alive on **Dec 4**, 19**54**, and that death occurred at **9:20 A.** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**A.S. Chalfant MD****6210 YORK ROAD, Baltimore, Md. March 9, 57**

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<b>REMOVAL</b>	<b>MAR. 10, 1957</b>	<b>USREY FUNERAL HOME</b>	<b>ANNISTON, ALABAMA</b>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	31. FUNERAL DIRECTOR	ADDRESS	
<b>Mar. 10, 1957</b>	<b>Mabel C. Gray</b>	<b>John Burnie' Love, Towson, Md.</b>		

MARGIN RESERVED FOR PRINTING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the cause of death clearly and legibly.

RECEIVED  
MAR 13 1957  
BUREAU V. S.

02656

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>1mth8dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOS. IT L</u>				d. STREET ADDRESS <u>2905 Garrison Blvd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. AGE OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Andrew</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>19 57</u>					
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 7, 1875</u>				
9. AGE (In years last birthday) yrs. <u>81</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>civil engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-- building</u>					
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>Joseph Moore</u>		14. MOTHER'S MAIDEN NAME <u>Jane Sloane</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>none</u>					
17. INFORMANT <u>Records: SPRING GROVE STATE HOS. ITAL</u>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchppneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>Feb. 27</u> , 19 <u>57</u> , to <u>March 12</u> , 19 <u>57</u> that I last saw the deceased alive on <u>March 12</u> , 19 <u>57</u> , and that death occurred at <u>3:15a</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Isadore Tuerk, M. D.</u> <u>SPRING GROVE STATE HOSPITAL</u> <u>3-12-57</u>							
ACTUAL SIGNATURE <u>Isadore Tuerk</u>		M.D. <u>SPRING GROVE STATE HOSPITAL</u>					
PHYSICIAN'S NAME (Type) <u>Isadore Tuerk, M. D.</u>		City <u>Catonsville 28, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/14/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lichtenor &amp; Sons - Builders</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 14 57</u>					
24b. REGISTRAR'S SIGNATURE <u>Paul</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 14 1957

RECEIVED

## 02657 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Ruxton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1814 Ruxton Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELISA</u> First <u>THOMAS</u> Middle <u>MORRIS</u> Last		4. DATE OF DEATH <u>MAR</u> Month <u>3</u> Day <u>1957</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 19 1857</u> 9. AGE (In years last birthday) <u>99</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Philadelphia PA</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>J THOMAS ELLIOTT</u>		14. MOTHER'S MAIDEN NAME <u>VICTORIA BALTZELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. Philip L Poe</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema.</u> <u>Aspiration Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis, generalized and cerebral.</u> DUE TO (c) <u>General arterio-scler</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Approx. 1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUT NG TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>Severe diverticulitis of colon; chronic cholelithiasis.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>March 3</u> p. m. <u>6:45</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> Home. <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home.</u>		20f. (City or town) <u>Ruxton 4, Maryland.</u> (County) (State)	
21. I certify that I attended the deceased from <u>1951</u> , 19 <u>  </u> , to <u>March 3, 1957</u> , that I last saw the deceased alive on <u>February 26, 1957</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. H. Rutledge</u> M.D.		DATE SIGNED <u>March 4, 1957</u>	
PHYSICIAN'S NAME (Type) <u>B. H. Rutledge, M. D.</u>		<u>18 East Eager Street, Baltimore 2, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>Mar 5 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill</u>	22d. LOCATION (City, town, or county) <u>Philadelphia Pa.</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins &amp; Sons</u> ADDRESS <u>4905 York Rd</u>		24a. RECEIVED BY REGISTRAR <u>Mar 5 1957</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Nabel Guy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. A. 5

RECEIVED

02658

## CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>34 Fullerton Heights Ave.</u>		d. STREET ADDRESS <u>34 Fullerton Heights Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>John L. Moyer</u>		4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1877</u>
9. AGE (In years last birthday) <u>79</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ferdinand Moyer</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Christina Moyer 34 Fullerton Hts. Ave.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>155x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma of Brain</u> DUE TO (c) <u>Carcinoma of Colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>2 weeks</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of the Prostate</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-1-</u> <u>1957</u> , to <u>3-31</u> <u>1957</u> , that I last saw the deceased alive on <u>3-31</u> <u>1957</u> , and that death occurred at <u>6:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul G. Mueller</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>6331 BELAIR RD.</u>	
PHYSICIAN'S NAME (Type) <u>Leonard J. Beck 5305 Hargord Rd.</u>		24b. REC'D BY REGISTRAR <u>APR 2</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/4/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parrwood Cemetery</u>		22d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Beck 5305 Hargord Rd.</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. A. L. Beesedey</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 2 1901

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02660

## 02659 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO, md.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO, Md.</u>		c. LENGTH OF STAY IN 1b <u>6 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>509 Welbrook Rd.</u>		d. STREET ADDRESS <u>511 Kenmore Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ina</u> Middle <u>S.</u> Last <u>Newberry</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 1889</u>
9. AGE (in years last birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Louisburg, N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Gideon Strickland</u>		14. MOTHER'S MAIDEN NAME <u>Martha Wheless</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Mrs. Lavalette W. Jackson 509 Welbrook Rd. 21</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>416x</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rheumatic Heart Disease, Advanced</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN. 1950</u> to <u>3/23, 1957</u> , that I last saw the deceased alive on <u>3/22, 1957</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph J. Cameron</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>30 CHANDELLE RD - BALTO, MD. 3/23/57</u>	
PHYSICIAN'S NAME (Type) <u>Joseph J. Cameron</u>		<u>30 Chandelle Rd. Balto, 20, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar. 26, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Spring</u>	22d. LOCATION (City, town, or county) (State) <u>Louisburg, N. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Lanok Funeral Home 7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 27 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>

RECEIVED

MAR 27 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02661

## 02660 CERTIFICATE OF DEATH

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn, Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>4 Russell Court</b>	
3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>F.</b> Last <b>Novak</b>		4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 30, 1873</b>
9. AGE (In years last birthday) <b>83</b> yrs		IF UNDER 1 YEAR Months <b>30</b> Days <b>19</b> Hours <b>57</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <del>Czechoslovakia</del> <b>Czechoslovakia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jordan Filipovsky</b>		14. MOTHER'S MAIDEN NAME <b>Barbara</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>219-03-3730</b>	
17. INFORMANT <b>Mrs. Agnes Whittington - 4 Russell Court</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hemiplegia right</b> <b>1143X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral hemorrhage, left</b> DUE TO (c) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>1 week</b> <b>10 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>22 January, 1955</b> , to <b>29 March, 1957</b> , that I last saw the deceased alive on <b>29 March, 1957</b> , and that death occurred at <b>1:45 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Millard T. Traband, Jr.</i>		ADDRESS (Street, city or town, state) DATE SIGNED <b>5101 Gwynn Oak Avenue, Baltimore, 7, Md. 30 March 57</b>	
PHYSICIAN'S NAME (Type) <b>Millard T. Traband, Jr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 3, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ellsworth Armacost</i>		24a. RECEIVED BY REGISTRAR <b>APR 1 1957</b>	
24b. REGISTRAR'S SIGNATURE <i>Dr. J. M. Martin</i>			

BUREAU V. S.

APR 1

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02546

## CERTIFICATE OF DEATH

02662 41

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1606 LESLIE AVE</u>				d. STREET ADDRESS <u>1606 LESLIE AVE</u>			
3. NAME OF DECEASED (Type or print) First <u>LEONA</u> Middle <u>MAE</u> Last <u>ORR</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 27, 1890</u>	
9. AGE (In years last birthday) <u>66</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>SAMUEL MONK</u>				14. MOTHER'S MAIDEN NAME <u>MINNIE ROOP</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>WM. D ORR 1606 LESLIE AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Pectum =</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 YR.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month <u>  </u> Day <u>19</u> Year <u>  </u> Hour a. <u>  </u> p. m. <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>MAY 1956</u> to <u>MARCH 2, 1957</u> , that I last saw the deceased alive on <u>FEB 28, 1957</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. B. Davis</u>				M.D. <u>6800 MORNINGTON RD 3/3/57</u>			
PHYSICIAN'S NAME (Type) <u>M. B. DAVIS M.D.</u>				ADDRESS (Street, city or town, state) <u>DUNDALK - 22 MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>MAR 3, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. PETERS LUTH.</u>		22d. LOCATION (City, town, or county) (State) <u>PITTSBURGH PA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ILLRICH FUNERAL HOME</u>				ADDRESS <u>2112 DUNDALK</u>		24a. REC'D BY REGISTRAR <u>MAR 4 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

RECEIVED

02661 CERTIFICATE OF DEATH

02663

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>✓</u>	
3. NAME OF DECEASED (Type or print) <u>DAISY</u> First <u>- PALMER</u> Middle Last		4. DATE OF DEATH <u>March 15</u> Month Day Year <u>1957</u>	
5. SEX <u>TH</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 13 - 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Granbury Boring</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>no</u>	
17. INFORMANT <u>Walter Elsewood - Upperco Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardis - Vascular Disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 13, 1957</u> to <u>March 15, 1957</u> that I last saw the deceased alive on <u>March 15, 1957</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>3/15/57</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		<u>Hampstead Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Mar 18 - 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wagon</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. Crpton</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>3-16-57</u>	24b. REGISTRAR'S SIGNATURE <u>Ann B. Elmer</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 19 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02664

## 02662 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Middle River</u> LENGTH OF STAY (in this place) <u>10 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Middle River</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2108 Old Eastern Ave</u>		STREET ADDRESS (If rural, give location) <u>2108 Old Eastern Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Lucas</u> (First) <u>Peterson</u> (Middle) <u>Peterson</u> (Last)	4. DATE OF DEATH <u>March 5</u> 19 <u>57</u> (Month) (Day) (Year)		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct 14 1875</u>
9. AGE last birthday <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Huber</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin Peterson</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>612058418A</u>	
17. INFORMANT AND ADDRESS <u>Frances Peterson 2108 Eastern Ave</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>Cerebral apoplexy</u>		(a)	<u>2 days</u>
Antecedent cause(s) <u>Arteriosclerosis Cardio Vascular</u>		(b)	<u>2 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Asane</u>		(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Feb 1</u> , 19 <u>57</u> , to <u>March 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 5</u> , 19 <u>57</u> , and that death occurred at <u>3:45 P</u> .m., from the causes and on the date stated above.			
SIGNATURE <u>W. Baumgardner MD</u>		DATE SIGNED <u>3/6/57</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE <u>MARCH 8-57</u>	NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEM</u>
LOCATION (City, town, or county) (State) <u>GERMAN HILL RD MD</u>		24. FUNERAL DIRECTOR <u>Duffel Bldg 7110 BELAIR RD.</u>	
DATE REC'D BY LOCAL REG. <u>3/8/57</u>		REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

MARGIN RESERVED FOR BINDER

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU Y. B.

MAR 11 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, marking the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02663

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

026658

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>White Marsh</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>2nd</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3006 Batavia Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILBUR</u> Middle <u>ELLSWORTH</u> Last <u>PLITT</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-5-1913</u>
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>	11. IF UNDER 24 HRS. Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edgar Plitt</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Carey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>yes</u> <u>1st Lt W.W.</u>		16. SOCIAL SECURITY NO. <u>220-07-4787</u>	
17. INFORMANT <u>Nephew</u>		Address <u>3006 Batavia Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Insufficiency</u> (c) <u>Coronary Insufficiency</u> DUE TO <u>Coronary Insufficiency</u> cause lost.		INTERNAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank T. Kasik</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK T. KASIK JR</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Mar 9 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/12/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #04</u>	
24a. REC'D BY REGISTRAR <u>Mar 12 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. M. Bacon</u>	

RECEIVED

MAR 12 1907

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02547 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02666

Reg. Dist. No. 41

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>895 STRICKER ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <u>VERL</u> Middle <u>—</u> Last <u>PORTER</u>			<b>4. DATE OF DEATH</b> Month <u>MARCH</u> Day <u>9</u> Year <u>1957</u>		
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>COLO</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>MARCH 11, 1914</u>		<b>9. AGE</b> (In years last birthday) <u>42</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>MECHANIST</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>BETH STEEL CO.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>KENTUCKY</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			<b>13. FATHER'S NAME</b> <u>JOHN PORTER</u>		
<b>14. MOTHER'S MAIDEN NAME</b> <u>AMERICA MILLER</u>			<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		
<b>16. SOCIAL SECURITY NO.</b>			<b>17. INFORMANT</b> <u>JOHN PORTER 2300 VALLEY ST. DAYTON OHIO</u>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> <u>823X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>CAR RAN OFF ROAD INTO BEAR CREEK—</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>12/3/57</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Dundalk - 2nd Bath</u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
<b>ACTUAL SIGNATURE</b> <u>M.B. Davis</u> <b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>					
<b>EXAMINER'S NAME (Type)</b> <u>M.B. DAVIS M.D.</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>					
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>REMOVAL</u>		<b>22b. DATE THEREOF</b> <u>3/11/57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Rocky Branch Cem.</u>	
<b>22d. LOCATION</b> (City, town, or county) (State) <u>Ellicott County Kentucky</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>ULRICH FUNERAL HOME, DUNDALK, MD.</u>			
<b>24a. REC'D BY REGISTRAR</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Am. M. Ellis</u>			

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MAR 12 1957

RECEIVED

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02667

## 02664 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>214 Glenrae Drive</u>				STREET ADDRESS (If rural give location) <u>214 Glenrae Drive</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>ZINA</u> <u>PREBISH</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>March 7</u> <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 15, 1882</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Russia</u> ✓
13. FATHER'S NAME <u>John Kozel</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Elizabeth Shipley-214 Glenrae Dr</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
X IMMEDIATE CAUSE (A) <u>Congestive Cardiac Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 wks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis - Generalized - severe</u>				<u>3 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Diabetes</u>				<u>10+ yrs</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetic Gangrene - left leg</u>				<u>3 mos</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>10/1/1956</u> , to <u>3/7/1957</u> , that I last saw the deceased alive on <u>3/7/1957</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> M.D. <u>Catonsville, Md</u> ADDRESS (Street, city, town, state) <u>Catonsville, Md</u> DATE SIGNED <u>3/8/57</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/9/1957</u>		NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR <u>57</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>ELLSWORTH ARMACOST-4600 Liberty</u>	
DATE <u>3/11/57</u>							

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy must be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be obtained with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transcript.

VS A15C 1-55 10M

MAR 11 1955

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BUREAU OF

## MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/55

RECEIVED

MAR 27 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02666

CERTIFICATE OF DEATH

02668

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore 19-</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>AS</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>IN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3119 Grace Ave</u>		d. STREET ADDRESS <u># 1.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MINNIE B. REESE</u>		4. DATE OF DEATH Month Day Year <u>MAR 27 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 8 1881</u>
9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EMANUEL TEMPLIN</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE STEVENS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>HARRY REESE</u>		Address <u>AS IN # 1.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SENILE ATHEROSCLEROSIS</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>LARGE VENTRAL HERNIA</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MAY 1954</u> to <u>MAY 1957</u> , that I last saw the deceased alive on <u>JAN 1957</u> , and that death occurred at <u>7:20</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis N. Toblin</u>		ADDRESS (Street, city or town, state) <u>6408 N. Point Rd</u>	
PHYSICIAN'S NAME (Type) <u>Louis N. Toblin</u>		DATE SIGNED <u>Balto 19-Md</u>	
22a. BURIAL OR CREMATION REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 29/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mount Vernon</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip A. Henry Sons</u>		24a. REC'D BY REGISTRAR <u>37</u>	
ADDRESS <u>2024 Orleans St</u>		24b. REGISTRAR'S SIGNATURE <u>Lawson L. Farley</u>	
DATE <u>MAR 29 1957</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 20 1957

BUREAU V. S.

## CERTIFICATE OF DEATH

Reg. Dist. No.

~~02667~~

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Caton Ridge Nursing Home, 329 Marlen Lane</b>		d. STREET ADDRESS <b>4109 Stokes Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>William S. Reid</b>		4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>1957</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 3, 1872</b>	9. AGE (In years last birthday) <b>85 yrs.</b>	10. IF UNDER 1 YEAR Months <b>85</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <b>Retired Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Paul Jones &amp; Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Reid</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>216 07 6042</b>		17. INFORMANT <b>Mrs. Phoebe May Reid</b>		Address <b>4109 Stokes Drive</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial insufficiency</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic Cardio-vascular disease</b> DUE TO (c) <b>central vascular accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>?</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>central vascular accident</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>0</b> m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 17, 1957</b> to <b>May 22, 1957</b> , that I last saw the deceased alive on <b>May 22, 1957</b> , and that death occurred at <b>8:00 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>4116 Edmondson Ave. Mar 24, 57</b>		DATE SIGNED <b>George A Knipp</b>			
ACTUAL SIGNATURE <b>George A Knipp</b>		M.D. <b>George A Knipp M.D.</b>					
PHYSICIAN'S NAME (Type) <b>George A Knipp</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 26/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn 7, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry H. Witzke</b>		ADDRESS <b>4101 Edmondson Ave.</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 26 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

may be removed by the registrar or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

18 27 1897

RECEIVED

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1 mth 4dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>2436 Dorton Court</b>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Edward</b> Last <b>Reinhardt</b>		4. DATE OF DEATH Month <b>3</b> Day <b>29</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 25, 1882 ?</b>
9. AGE (In years last birthday) <b>74</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>clothing</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Louis Reinhardt</b>		14. MOTHER'S MAIDEN NAME <b>Emma Harrison</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO <b>213-20-2014</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 27, 19 57</b> to <b>March 29, 19 57</b> , that I last saw the deceased alive on <b>March 29, 19 57</b> , and that death occurred at <b>9:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Jerome E. Shapiro</b>		DATE SIGNED <b>3/29/57</b>	
PHYSICIAN'S NAME (Type) <b>JEROME E. SHAPIRO, M.D.</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-2-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lougon Park Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Rd Balto Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Toulson</b>		24a. REC'D BY REGISTRAR <b>APR 1 '57</b>	
ADDRESS <b>2359 Wash Blvd Balto 30 Md</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 1 1911

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For use of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02669

## CERTIFICATE OF DEATH

02671

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Inverness</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Inverness</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>20 Seabright Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>R.</b> Last <b>RODGERS</b>		4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 27, 1891</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Novak</b>		14. MOTHER'S MAIDEN NAME <b>Betty Meka</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Em. A. Rodgers 20 Seabright Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>metastatic Carcinoma</b> <b>175x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cystadenocarcinoma OVARY</b> (c) <b>Carcinoma CERVIX</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/18</b> , 19 <b>57</b> , to <b>3/24</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3/24</b> , 19 <b>57</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>John E. Grossner</b> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>March 27, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home 2112 Dundalk Ave.</b>		24a. REC'D BY REGISTRAR <b>DATE 3/26/57</b>	24b. REGISTRAR'S SIGNATURE <b>Edith Hurley</b>

RECEIVED

MAR 27 1957

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02672

02548

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	
TOWN <u>1122</u>		TOWN <u>1122</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>211 Hendricks ET.</u>		STREET ADDRESS (If rural, give location) <u>211 Hendricks ET.</u>	
3. NAME OF DECEASED (First) <u>Alice</u> (Middle) (Last) <u>Rogers</u>		4. DATE OF DEATH <u>3-2-1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Sept. 23, 1906</u>
9. AGE last birthday <u>50</u> yrs.		10. AGE last birthday If under 1 year Months <u>5</u> Days <u>12</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTH PLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Allen Alston</u>		14. MOTHER'S MAIDEN NAME <u>Morrison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Israel W. Rogers 211 Hendricks ET. #22</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

1 hour

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertensive Cardio-Vascular Disease1 yr.

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>HOMICIDE</u>		(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR?				
OF INJURY	While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>					

22. I hereby certify that I attended the deceased from Jan., 1946, to March 2, 1957, that I last saw the deceased alive on February 20, 1957, and that death occurred at 9:45 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

William C. Stadel, M.D., 140 Oak Avenue, Dundalk 1122, Md. D-2-57

23. BURIAL, CREMATION OR TOWAL (Specify) <u>Burial</u>	DATE THEREOF <u>3-7-57</u>	NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>	LOCATION (City, town, or county) <u>Balto., Md.</u>	(State)
DATE RECD BY LOCAL REG. <u>3/7/57</u>	REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>	24. FUNERAL DIRECTOR <u>Charles R. Law</u>	ADDRESS <u>802 Madison Ave.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 8 1957

BUREAU V. 31

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and far use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02670

## CERTIFICATE OF DEATH

02673

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 3V01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in Pines, 16 Fusting Ave</b>		d. STREET ADDRESS <b>204 S. Fulton Ave</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>William W. Russell, Jr.</b>		4. DATE OF DEATH Month Day Year <b>March 18/57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 3, 1906</b>
9. AGE (In years last birthday) <b>50</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chemical Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dupont Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William W. Russell Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Emma</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Mrs. Arvella Russell, 204 S. Fulton Ave</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>157X Carcinoma of Pancreas &amp; Generalized Carcinomatosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1954</b> , 19 to <b>3/18</b> , 1957, that I last saw the deceased alive on <b>3/17</b> , 1957, and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John C. Healy</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>Baltimore Md 3/19/57</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/21/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>A.A. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry H. Witzke, 4101 Edmondson Ave</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 20 '57</b>	
24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>			

RECEIVED

MAR 20 1907

BUREAU A. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
13M 9/55

02671 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										026743/	
Items 14, 22c: G213 5-11-57L										CERTIFICATE OF DEATH	
										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE <u>Delaware</u> c. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Swains Oak</u>					c. LENGTH OF STAY IN 1b <u>4 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delaware</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Augsburg Home</u>					d. STREET ADDRESS <u>Bay Rd. Dover Del</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Duck</u> First Middle Last <u>Kuyper</u>					4. DATE OF DEATH <u>March 28</u> Month Day Year <u>1957</u>						
5. SEX <u>m</u>		6. COLOR OR RACE <u>w</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 19, 1870</u>		9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Peter</u>					14. MOTHER'S MAIDEN NAME <u>CATHERINA VAN DYKE</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <u>Records AUGSBURG HOME</u> Address <u>6811 CAMPFIELD</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>11 - Arterio Sclerotic Heart Disease</u> <u>400.0</u> DUE TO (b) <u>21 - Generalized Arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>31 - Mal-nutrition</u>										INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.?</u> <u>2 yrs.</u> <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Jan - 17 -</u> , 1957, to <u>March 28</u> , 1957, that I last saw the deceased alive on <u>March - 28</u> , 1957, and that death occurred at <u>7 P.</u> M, from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>Earl L. Chambers</u>					ADDRESS (Street, city or town, state) <u>4108 Liberty Hts Ave - Balto - Md</u> DATE SIGNED <u>7-Mch-57</u>						
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>					ADDRESS (Street, city or town, state) <u>4108 Liberty Hts Ave - Balto - Md</u> DATE SIGNED <u>7-Mch-57</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)			
<u>BURIAL</u>		<u>3/31/57</u>		<u>DOVER DEL</u>		<u>Odd Fellows</u>		<u>Del.</u>		<u>Camden</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul Heumann</u> ADDRESS <u>6067 Hayford Rd</u>					24a. REC'D BY REGISTRAR <u>APR 2 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Jm. E. Martin</u>				

MEDICAL CERTIFICATION

BUREAU V. S.

APR

RECEIVED

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ARBUTUS</b>		c. LENGTH OF STAY IN 1b <b>4 YRS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>57 ARBUTUS BALTIMORE COUNTY MD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4210 Maryland Place</b>				d. STREET ADDRESS <b>4210 Maryland Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>KLARA RUZICKA</b>		First Middle Last		4. DATE OF DEATH <b>March 14, 1957</b>		Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 3, 1887</b>		9. AGE (In years last birthday) <b>69</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>Austria</b> ✓	
13. FATHER'S NAME <b>Ferdinand Kisling</b>				14. MOTHER'S MAIDEN NAME <b>Anna M. Steiner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Marie Blaschek, 4210 Maryland Place</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>175x Carcinoma of Ovary &amp; Metastases</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Sept 1956</b> to <b>March 14, 1957</b> , that I last saw the deceased alive on <b>March 14, 1957</b> , and that death occurred at <b>11:15 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>I. EARL PASS, M.D.</b>		M.D. <b>4001 Wilkens Ave</b>		ADDRESS (Street, city or town, state) <b>BALTIMORE</b>		DATE SIGNED <b>3-15-57</b>	
PHYSICIAN'S NAME (Type) <b>I. EARL PASS, M.D.</b>		M.D. <b>4001 Wilkens Ave</b>		ADDRESS (Street, city or town, state) <b>BALTIMORE</b>		DATE SIGNED <b>3-15-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-16-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge</b>		22d. LOCATION (City, town, or county) <b>Howard County, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>				ADDRESS <b>4107 Wilkens Ave</b>		24a. REC'D BY REGISTRAR <b>DATE 15</b>	
				24b. REGISTRAR'S SIGNATURE <b>Dr. Geo. M. Kuffner</b>			

RECEIVED

MAR 15 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

Item 18 Film 212

02672

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02676

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>15 hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) First <b>Jerome</b> Middle <b>Ridgeway</b> Last <b>Samuels</b>		4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 13, 1921</b>
9. AGE (In years last birthday) <b>35 yrs.</b>		10. IF UNDER 1 YEAR Months <b>35</b> Days <b>35</b> Hours <b>35</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Harlan A. Samuels</b>		14. MOTHER'S MAIDEN NAME <b>Nellie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>219-03-6429</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>581.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Delirium tremens due to Chronic Alcoholism</b> (c) <b>Diffuse nodular cirrhosis of the liver</b> DUE TO cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>on floor of sideroom; apparently without respirations; pronounced dead at 7:30 a.m.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pt. discovered lying on floor of sideroom; apparently without respirations; pronounced dead at 7:30 a.m.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>George M. Kieffer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>		DATE SIGNED <b>3-20-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>		22b. DATE THEREOF <b>3/23/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McGully Funeral Homes - 130 E. Fort Avenue</b>		24a. REC'D BY REGISTRAR <b>W. H. Houch</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
DATE		DATE	

BUREAU V. S.

3/26

ST. S. K.

RECEIVED  
MAR 27 1926

# MARYLAND STATE DEPARTMENT OF HEALTH

02677

02673

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. . . . .

1. PLACE OF DEATH COUNTY <u>Baltimore County</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Calonsville, Md</u> TOWN <u>Balto Co.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>3101-4</u> TOWN <u>7. Calvert</u>	
3. NAME OF DECEASED (Type or Print) <u>Cress</u> (First) <u>Woland</u> (Middle) <u>Scarff</u> (Last)		4. DATE OF DEATH (Month) <u>Mar</u> (Day) <u>11</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>April 2, 1874</u> 82 yrs.	
9. AGE last birthday <u>82</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Harford Co. Md</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Wm C. Barington</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Pierce</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Grace Howell Joppa Md</u>			

### 18. MEDICAL CERTIFICATION

#### 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Myocardial failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c) Arteriosclerosis, generalized

INTERVAL BETWEEN ONSET AND DEATH  
29 hrs.

#### 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Hemiplegia central vascular accident 6 mos.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-1, 1957, to 3-11, 1957, that I last saw the deceased

alive on 3-11, 1957, and that death occurred at 115 P.m., from the causes and on the date stated above.

SIGNATURE <u>Stephen Lee Lapreces MD</u>	DATE SIGNED <u>3-11-57</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Mar 14 57</u>
NAME OF CEMETERY OR CREMATORY <u>Mountain Church</u>	LOCATION (City, town, or county) <u>Joppa Md</u>
DATE REC'D BY LOCAL REG. <u>Mar 18 57</u>	REGISTRAR'S SIGNATURE <u>Arthur</u>
24. FUNERAL DIRECTOR <u>W. Archer</u>	ADDRESS <u>Brown Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

1967

RECEIVED

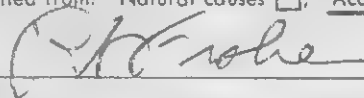


# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02560 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02678

Reg. Dist. No.

41

<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus -27</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Knea cht Ave. &amp; Penna. R.R.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTO. 3401-4</b> d. STREET ADDRESS <b>3910 Colchester Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) First <b>JOHN</b> Middle <b>P.</b> Last <b>SCHEURECKER</b>		<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>25</b> Year <b>19 57</b>		<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>AUG. 29, 1904</b>		<b>9. AGE</b> (In years last birthday) <b>52 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Butcher</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>GERMANY</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>JOHN P. SCHEURECKER</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>ANNA STRIMLICK</b>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <b>216-13-0956</b>				<b>16. SOCIAL SECURITY NO.</b> <b>216-13-0956</b>				<b>17. INFORMANT</b> Address <b>3910 Colchester Rd.</b> <b>MRS MYRTLE SCHEURECKER</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple extreme injuries</b> DUE TO <b>810X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile struck by freight train</b>															
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>11:30 a.m. 3/25 19 57</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Street</b>				<b>20f. (City or town)</b> (County) (State) <b>Baltimore Md.</b>									
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> <b>Accident</b> <input checked="" type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined cause</b> <input type="checkbox"/>																			
<b>ACTUAL SIGNATURE</b> 				<b>EXAMINER'S NAME</b> (Type) <b>Russell S. Fisher, M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <b>3/26/57</b>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>				<b>22b. DATE THEREOF</b> <b>MAR. 30/57</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>MEADOW RIDGE</b>				<b>22d. LOCAT OF</b> (City, town, or county) (State) <b>POKESY MD</b>									
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> 				<b>ADDRESS</b> <b>4101 EDMUNDSON</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE 3/28/57</b>				<b>24b. REGISTRAR'S SIGNATURE</b> 							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to cremation, or removal.

BUREAU A. B.

1957

RECEIVED

02679

02674

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN TB <b>1 mth 18dys</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland</b>		d. STREET ADDRESS <b>1016 Russell Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Schmidt</b> Last <b>Schmidt</b>		4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 3, 1868</b>
9. AGE (In years last birthday) <b>88</b> yrs		IF UNDER 1 YEAR Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min. <b>88</b>	IF UNDER 24 HRS Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min. <b>88</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none (Housewife)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Roth</b>		14. MOTHER'S MAIDEN NAME <b>Margaret ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized and severe</b> DUE TO (c) <b>---</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>---</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>---</b> a. m. <b>---</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 8</b> , 19 <b>57</b> , to <b>March 26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>March 26</b> , 19 <b>57</b> , and that death occurred at <b>5:00 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>Stella Wachslar</b>			
ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D. <b>SPRING GROVE STATE HOSPITAL</b>			
PHYSICIAN'S NAME (Type) <b>STELLA WACHSLER</b> <b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-29-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR <b>3/29/57</b>	
24b. REGISTRAR'S SIGNATURE <b>A. J. Hedrick</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR

BUREAU V

## 02675 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CARNEY</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 CARNEY</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9811 HARTFORD RD</b>				d. STREET ADDRESS <b>1 9811 HARTFORD RD</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>WILLIAM C SCHNEIDER</b>				4. DATE OF DEATH <b>MARCH 18 1957</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 5 1881</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GRUVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FLORIST</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN SCHNEIDER</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE NEIGHART</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>-</b>			
17. INFORMANT <b>MARY SCHNEIDER</b>				Address <b>9811 HARTFORD RD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> (c) <b>Normal Aging</b>							INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Possible dissecting Aneurysm</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <b>Jan</b> Day <b>1</b> Year <b>1953</b> Hour <b>a. m.</b> <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Carney</b> (County) <b>MD</b> (State) <b>MD</b>							
21. I certify that I attended the deceased from <b>Jan 1, 1953</b> to <b>Mar 17, 1957</b> , that I last saw the deceased alive on <b>Mar 17, 1957</b> , and that death occurred at <b>12:40 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Frank T. Kasik, Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>9005 Hartford Rd, Balto 74, Md</b>			
DATE SIGNED <b>3/19/57</b>							
PHYSICIAN'S NAME (Type) <b>FRANK T. KASIK, JR</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-21-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD</b>		22d. LOCATION (City, town, or county) <b>BALTO MD</b> (State) <b>MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>CHAS F. EVANS &amp; SON</b>				ADDRESS <b>8802 HARTFORD RD</b>			
24a. REC'D BY REGISTRAR <b>DATE</b>				24b. REGISTRAR'S SIGNATURE <b>Dr. H. M. Barrow</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1  
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delayed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02676 CERTIFICATE OF DEATH

02681 45

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTC.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE <u>MD</u> c. COUNTY <u>BALTC.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAPE MAY</u> <u>June 21</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XUCAPE MAY</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>501 SCHOTTS RD.</u>			d. STREET ADDRESS <u>1501 SCHOTTS RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>BENJAMIN SCHOTT</u>			4. DATE OF DEATH <u>MAR. 21 1957</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 2 1885</u>	9. AGE (In years last birthday) <u>72</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>BALTC. MD.</u>	
13. FATHER'S NAME <u>BERNHARDT SCHOTT</u>			14. MOTHER'S MAIDEN NAME <u>F.L.Z. ?</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>FRIEDA SCHOTT</u> Address <u>501 SCHOTTS RD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>March 19, 1957</u> to <u>March 21, 1957</u> , that I last saw the deceased alive on <u>March 21, 1957</u> , and that death occurred at <u>12:00 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>James F. White</u>		M.D. <u>422 Eastern Ave., Baltimore 21, MD</u>		DATE SIGNED <u>3/4/57</u>	
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)		
<u>BURIAL</u>	<u>3/25/57</u>	<u>CAN LAWN</u>	<u>BALTC. MD.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly</u>		ADDRESS <u>June 21 2nd</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Edith Parley</u>
				DATE <u>MAR 28 1957</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02677 CERTIFICATE OF DEATH

02682 38

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8755 Old Harford Road</u>				d. STREET ADDRESS <u>8755 Old Harford Road</u>			
3. NAME OF DECEASED (Type or print) <u>Mr. Ernest F. Sharff</u>				4. DATE OF DEATH <u>March 12th 1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 7, 1869</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Internal Revenue</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Martinsburg, W. Va</u>	
13. FATHER'S NAME <u>Sharff</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Ford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>579-14-0258 A.</u>		17. INFORMANT <u>Mr. Cyril S. Sharff</u> Address <u>4676 Marble Hall Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Jan 1, 1957</u> , to <u>March 12, 1957</u> , that I last saw the deceased alive on <u>March 11, 1957</u> , and that death occurred at <u>7:25</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. A. Grotz</u>				ADDRESS (Street, city or town, state) <u>8755 Old Harford Rd</u> DATE SIGNED <u>3/13/57</u>			
PHYSICIAN'S NAME (Type) <u>H. A. GROTZ, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/15/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR <u>Dr. M. Bacon</u>		24b. REGISTRAR'S SIGNATURE	

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BUREAU V. S.

02678

## CERTIFICATE OF DEATH

02683

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>2yr6mth24dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>8222 Fort Smallwood Rd.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>Shauck</b> Last <b>Howard</b>				4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>19 57</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>Separated</b>		8. DATE OF BIRTH <b>Aug. 19, 1880</b>	
9. AGE (In years last birthday) <b>76</b> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>textile worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>cotton mills</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Shauck</b>				14. MOTHER'S MAIDEN NAME <b>Sadie Boston</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-07-6457</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>4</b> DUE TO <b>Senile arteriosclerotic nephrosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 4, 1957</b> , to <b>March 13, 1957</b> , that I last saw the deceased alive on <b>March 13, 1957</b> , and that death occurred at <b>9:30 a. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>3-13-57</b>							
ACTUAL SIGNATURE <b>Stella Wachsler</b> M.D.				PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>3-16-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST MARY'S</b>	
22d. LOCATION (City, town, or county) <b>HAMPDEN</b>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul E. Schenck</b> ADDRESS <b>3615-17 Chestnut</b>				24a. REC'D BY REGISTRAR <b>W. Schenck</b> DATE <b>MAR 15 57</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAR 18 1957

BUREAU V. S.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02679

## CERTIFICATE OF DEATH

02684

44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>10 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>2000 Clifton Avenue, Baltimore City</b>			
3. NAME OF DECEASED (Type or print) First <b>CALVIN</b> Middle <b>F.</b> Last <b>SHEWBRIDGE</b>				4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 23, 1897</b>		9. AGE (In years lost birthday) yrs <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Army</b>		11. BIRTHPLACE (State or foreign country) <b>Harpers Ferry W. Virginia</b>	
13. FATHER'S NAME <b>Elmer E. Shewbridge</b>				14. MOTHER'S MAIDEN NAME <b>Annie Dewy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>215-12-4094</b>		17. INFORMANT Address <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO <b>ARTERIOSCLEROTIC CORONARY THROMBOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b> <b>UNKNOWN</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>9</b> a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>March 10</b> , 19 <b>57</b> , to <b>March 20</b> , 19 <b>57</b> <del>XXXXXX XXXXX XXXXX</del> and that death occurred at <b>6:10 A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Irving Freeman</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> <b>3/20/57</b> PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D. Chief, Medical Service</b> <b>VAH, FORT HOWARD, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/24/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clarence Hoffmann</b>				24a. REC'D BY REGISTRAR DATE <b>22 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Taylor</b>	
Clarence Hoffmann Funeral Home, 3218 Hudson St. Baltimore, Md.							

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02685  
02680 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows P BALTIMORE</b> c. LENGTH OF STAY IN 1b <b>Bethlehem Steel Co. Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore Sparrows Point</b> d. STREET ADDRESS <b>326 W. Camden St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Shreve, Jr.</b> Last <b>Shreve, Jr.</b>		4. DATE OF DEATH Month <b>3</b> Day <b>26</b> Year <b>57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>November 23, 1918</b>
9. AGE (In years last birthday) <b>37</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>7</b>	IF UNDER 24 HRS. Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector Learner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Ed Shreve</b>	
14. MOTHER'S MAIDEN NAME <b>Stella Moudy</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>	
16. SOCIAL SECURITY NO. <b>WM 11</b>		17. INFORMANT <b>Lura Loenichen, 2704 Fenimore St., Wheaton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> DUE TO (c) <b>420.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>420.1</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>While at work</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>M. B. Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>M. B. Davis, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>3-26-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>March 29, '57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Catonsville Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Homes</b>		24. REC'D BY REGISTRAR <b>4210 Belair Rd., Balto.</b>	
24b. REGISTRAR'S SIGNATURE <b>3/28/57</b>		24c. REGISTRAR'S SIGNATURE <b>Lawson L. Harvey</b>	

RECEIVED

MAR 2 1957

BUREAU V. S.

02561 CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Halethorpe</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1806 Park Avenue</b>		d. STREET ADDRESS <b>1806 Park Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>NORMA DAISY MCDONALD</b>		4. DATE OF DEATH Month <b>3</b> Day <b>22</b> Year <b>1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 8, 1908</b>
9. AGE (In years last birthday) <b>49 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles McDonald</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Ellen Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Lewis Schuebel</b>		Address <b>Halethorpe, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Breasts with</b> <b>110X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Generalized Carcinomatosis</b> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August, 1956</b> , to <b>3/22, 1957</b> , that I last saw the deceased alive on <b>3/21, 1957</b> , and that death occurred at <b>12:30 P.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John C. Healy</b> M.D.		ADDRESS (Street, city or town, state) <b>Halethorpe Md</b> DATE SIGNED <b>3/22/57</b>	
PHYSICIAN'S NAME (Type) <b>John C. Healy</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-25-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Savage Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Savage, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>McKitt Connellean Laurel Md</b>		24. REC'D BY REGISTRAR DATE <b>MAR 28 1957</b>	
25. REGISTRAR'S SIGNATURE <b>Dr. B. M. Tuffey</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 24 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 48 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/35

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
02681 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02687  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u>		c. LENGTH OF STAY IN 1b <u>Baltimore 24/ 29</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Lethlean Steel Co. Dispensary</u>		d. STREET ADDRESS <u>1107 Woodington Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>P.</u> Last <u>Smiley</u>		4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 1, 1915</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>5</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ironworker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles L. Smiley</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Marie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes M. W. II</u>		16. SOCIAL SECURITY NO. <u>22002552</u>	
17. INFORMANT <u>Wife</u>		Address <u>Margaret Smiley-1107 Woodington Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple fractures including skull, pelvis, spine and left hip.</u> 902.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from crane to ground approx. 80 feet.</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:25</u> Hour <u>2:25</u> p. m. <u>3-12-1957</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Beth. Steel Co.</u>		20f. (City or town) (County) (State) <u>Sparrows Point-19, Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M. B. Davis M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. DAVIS M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/15/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethesda National</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda 19, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. White</u>		ADDRESS <u>401 Edmontown</u>	
24a. REC'D BY REGISTRAR <u>MAR 11 1957</u>		DATE <u>3/12/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Dawson L. Taylor</u>			

RECEIVED

MAR 14 1957

BUREAU V. A.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02688

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

02682

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md</u>	COUNTY
CITY (if outside corporate limits, write RURAL or and give nearest town) <u>Rosedale</u>	LENGTH OF STAY (in this place)	CITY (if outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1416 Rosewick Ave</u>		STREET ADDRESS (if rural give location) <u>1416 Rosewick Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>BELLE</u> (First) <u>SMITH</u> (Middle) (Last)		4. DATE OF DEATH <u>MARCH</u> <u>23</u> <u>1957</u> (Month) (Day) (Year)	
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Russia</u>
13. FATHER'S NAME <u>Not Known</u>		14. MOTHER'S MAIDEN NAME <u>Sophie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS <u>Sarah Comstock - same</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>CORONARY OCCLUSION</u>			<u>2 minutes</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIO SCLEROSIS</u>			<u>5 YEARS</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>APRIL 3</u> , 19 <u>52</u> , to <u>MARCH 23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-23</u> , 19 <u>57</u> , and that death occurred at <u>11:20 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>James R. M... M.D.</u>		DATE SIGNED <u>3-23-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3-24-57</u>	
NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>		LOCATION (City, town, or county) <u>Balto Md</u>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Eutan Pl</u>	
DATE <u>MAR 20 1957</u>		REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M-

BUREAU V. B.

MAR 28 1957

RECEIVED

02683

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>4 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Caton Ridge Nursing Home</b> <b>Marlow Lane near Edmondson Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Jessie First Middle Albert Smith</b>		4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 20, 1882</b>
9. AGE (In years last birthday) <b>74</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>8</b> Days <b>00</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania, Buck Co.</b>	
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>George Smith</b>		14. MOTHER'S MAIDEN NAME <b>Ida Mellott</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Estel J. Smith, 4212 Doris Ave - 25</b>		Address <b>4212 Doris Ave - 25</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left sided cardiac failure</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial degeneration</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>NOV 10, 1956</b> , to <b>MARCH 20, 1957</b> , that I last saw the deceased alive on <b>MARCH 19, 1957</b> , and that death occurred at <b>8:20 A.M.</b> , from the causes and on the date stated above.			
ACTUAL <b>Cliff Ratliff Jr.</b> M.D. <b>4605 Edmondson Ave</b>		DATE SIGNED <b>3/21/57</b>	
PHYSICIAN'S NAME (Type) <b>CLIFF RATLIFF, JR.</b>		<b>4605 EDMONDSON AVE.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-23-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Nebo Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Morgan County, W. Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>David R. Martin</b> <b>David R. Martin, 1902 Antway Place</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 26 57</b>	24b. REGISTRAR'S SIGNATURE <b>Overman</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

MAR 10 1907

RECEIVED

02684

## CERTIFICATE OF DEATH

02690

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNAPOLIS</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>1013 JACKSON STREET</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>LEONA</b> Middle <b>TOWNSON</b> Last <b>SMITH</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>25</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG 1, 1892</b>	
9. AGE (In years last birthday) <b>64 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>Benjamin Townson</b>				14. MOTHER'S MAIDEN NAME <b>Susan Mobray</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>HARRY SMITH</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Subacute bacterial endocarditis</b> <b>430.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN 15, 1957</b> to <b>MAR 25, 1957</b> , that I last saw the deceased alive on <b>MAR 25, 1957</b> , and that death occurred at <b>3:40 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D. <b>SPRING GROVE STATE HOSPITAL 3-25-57</b> PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b> <b>Catonsville 28, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-27-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SPRING HILL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>EASTON MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN M. TAYLOR</b> ADDRESS <b>SON ANNAPOLIS MD.</b>				24a. REC'D BY REGISTRAR <b>MAR 26 1957</b>		24b. REGISTRAR'S SIGNATURE <b>A. H. Hewitt</b>	

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAR 27 1957

BUREAU V. S.

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Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02685 CERTIFICATE OF DEATH

Reg. Dist. No.

02691

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>198 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 Baltimore</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SAM (NMI) SONGER</b>		4. DATE OF DEATH Month Day Year <b>March 15 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/23/88</b>
9. AGE (In years last birthday) yrs <b>68</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City</b>	
11. BIRTHPLACE (State or foreign country) <b>Ashland, Ky.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Cris Songer</b>		14. MOTHER'S MAIDEN NAME <b>Lizzie West</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W.W.I.</b>		16. SOCIAL SECURITY NO. <b>234-16-4256</b>	
17. INFORMANT <b>Clin. Rec. Vets. Administration Hosp. Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> <b>11/24/1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile emphysema, severe. Pulmonary fibrosis. Bronchiectasis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 29, 1956</b> to <b>March 15, 1959</b> , that I last saw the deceased on <b>March 15, 1959</b> , and that death occurred at <b>8:05 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Veterans Administration Hospital</b> DATE SIGNED <b>3/16/59</b>			
ACTUAL SIGNATURE <b>J. A. Baranowski M.D.</b>		M.D. <b>Veterans Administration Hospital</b>	
PHYSICIAN'S NAME (Type) <b>J. A. BARANOWSKI, M.D.</b>		Fort Howard, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-19-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc.</b>		ADDRESS <b>St. Paul &amp; Preston Sts, Balto., Md.</b>	
24a. REC'D BY REGISTRAR <b>181-77</b>		24b. REGISTRAR'S SIGNATURE <b>Lawson L. Farley</b>	

ALFRED V. S.

1957

RECEIVED

02686

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>EDGEHIRE 19</u>				c. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>EDGEHIRE (19)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2819 WELLS AVE.</u>				e. STREET ADDRESS <u>2819 WELLS AVE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>RONALD WAYNE SPARKS</u>				4. DATE OF DEATH Month Day Year <u>MAR. 30, 1957</u>			
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 17, 1939</u>	9. AGE (In years last birthday) yrs. <u>17</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LOUIS H. SPARKS</u>				14. MOTHER'S MAIDEN NAME <u>NAOMIE LEE SPARKS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>226369957</u>		17. INFORMANT <u>LOUIS H. SPARKS</u>		Address <u>— SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myelocytic Leukemia</u> 4.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 4, 1957</u> , to <u>March 30, 1957</u> , that I last saw the deceased alive on <u>March 30, 1957</u> , and that death occurred at <u>6:35</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David Owens</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>914 D St. Balto. Md. 3/30/57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-2-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CARL HINN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Burke Bachy, Licensed, Md.</u>				ADDRESS <u>—</u>		24a. REC'D BY REGISTRAR <u>APR 2 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>—</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event with n 72 hours after death.

BUREAU V. S.

APR 9 1911

RECEIVED

02687

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>14yr4mth8dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ELSIE</b> First Middle Last <b>STANDIFORD</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>15</b> Year <b>1957</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1872</b>	9. AGE (In years last birthday) <b>84</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>York, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Isaac Reider</b>				14. MOTHER'S MAIDEN NAME <b>Amanda?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOS ITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>NOV. 7, 1942</b> to <b>MAR. 15, 1957</b> that I last saw the deceased alive on <b>MAR. 15, 1957</b> and that death occurred at <b>12:25 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>MAR 15, 1957</b>							
ACTUAL SIGNATURE <b>Jerome E. Shapiro</b> M.D.				PHYSICIAN'S NAME (Type) <b>Jerome E. Shapiro, M. D.</b> <b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-18-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spring Grove State Hospital</b>		22d. LOCATION (City, town, or county) (State) <b>Catonsville 28, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Spring Grove State Hospital, Catonsville 28, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE MAR 26 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>	

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02688

## CERTIFICATE OF DEATH

02694

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1yr7mth23dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>4812 Haddon Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Stanley</b> Middle <b>Stanley</b> Last <b>Stanley</b>		4. DATE OF DEATH Month <b>March</b> Day <b>17</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-15-?</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>steward</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Standard Oil Co.</b>	9. AGE (In years last birthday) yrs. <b>63?</b>
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes 1917</b>		16. SOCIAL SECURITY NO. <b>090-14-2084</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal bronchopneumonia</b> DUE TO <b>Cerebral thrombosis and Encephalomalacia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis, generalized</b> (c) <b>Cerebral arteriosclerosis, generalized</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 14, 1957</b> , to <b>March 17, 1957</b> , that I last saw the deceased alive on <b>March 17, 1957</b> , and that death occurred at <b>8<sup>00</sup> p. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>William N. Karb, Jr.</b> M.D. <b>SPRING GROVE STATE HOSPITAL</b>		PHYSICIAN'S NAME (Type) <b>William N. Karb, Jr., M.D. Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-21-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Trinity</b>	22d. LOCATION (City, town, or county) (State) <b>Elkridge Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lambros Inc. 440 E. North Av</b>		24a. REC'D BY REGISTRAR <b>3/20/57</b>	24b. REGISTRAR'S SIGNATURE <b>A. J. Hedrick</b>

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MAR 21 1957

BUREAU V. S.

02562

## CERTIFICATE OF DEATH

Reg. Dist. No.

47

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>English Consul</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3222 Magnolia Ave.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>English Consul</b>			
f. STREET ADDRESS <b>3222 Magnolia Ave.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CATHERINE</b> Middle <b>A.</b> Last <b>STEWART</b>				4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>19 57</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 5, 1878</b>	
9. AGE (In years last birthday) <b>79 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>August Dorrier</b>				14. MOTHER'S MAIDEN NAME <b>Mathilda Obercht</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Harry T. Stewart - 3222 Magnolia Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>---</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>June 10, 1948</b> to <b>March 30, 1957</b> , that I last saw the deceased alive on <b>March 28, 1957</b> , and that death occurred at <b>4:25 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4808 Harford Rd. Balto. VI, Md.</b> DATE SIGNED <b>---</b>							
ACTUAL SIGNATURE <b>George Sawyer</b> M.D.				PHYSICIAN'S NAME (Type) <b>GEORGE SAWYER M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>4/2/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>	
22d. LOCATION (City, town, or county) <b>Woodlawn, Md.</b>				22e. (State) <b>Md.</b>		22f. (County) <b>Balto.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons - Baltore</b>				ADDRESS <b>---</b>		24a. REC'D BY REGISTRAR DATE <b>4/6/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Dr. E. M. Lickner</b>				24c. (State) <b>Md.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 2 1977

BUREAU V. S.

02689

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>33 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. STREET ADDRESS <b>Pleasant Hill Park</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>OSCAR</b>		First Middle Last <b>F. STIERHOFF</b>		4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 2, 1893</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bricklayer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>		11. BIRTHPLACE (State or foreign country) <b>Pikesville, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>George Stierhoff</b>		14. MOTHER'S MAIDEN NAME <b>Emma Bunn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>218-07-9792</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>AORTIC STENOSIS; CONGESTIVE HEART FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>February 21, 1957</b> , to <b>March 26, 1957</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above. GIVE ON _____ ADDRESS (Street, city or town, state) DATE SIGNED <b>ROLANDO D. PONCE DE LEON, M.D. VAH, FORT HOWARD, MARYLAND 3/26/57</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>ROLANDO D. PONCE DE LEON, M.D. VAH, FORT HOWARD, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 29, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Horace F. Burgee</b>				ADDRESS <b>3631 Falls Road, Baltimore, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAR 28 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Dawson L. Farley</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 22 1977

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02690

## CERTIFICATE OF DEATH

02697  
37

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		3. NAME OF DECEASED (Type or print) <u>(Anton)</u> First <u>ANTHONY</u> Middle <u>JOSEPH</u> Last <u>STILLING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>		d. STREET ADDRESS <u>1916 Christian St</u>	
4. DATE OF DEATH Month <u>3</u> Day <u>24</u> Year <u>1957</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1. 31. 86</u>
9. AGE (In years last birthday) <u>71</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INDUSTRIAL</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK STILLING</u>		14. MOTHER'S MAIDEN NAME <u>THERESA SCHUB</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT Address <u>Hospital records, Mt. Wilson State hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY INSUFFICIENCY</u> DUE TO (b) <u>PULMONARY TUBERCULOSIS, far advanced</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROSIS, HYPOCHROMIC ANEMIA, DEHYDRATION.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <u>Not while</u> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1-18</u> , 19 <u>57</u> , to <u>3-24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-24</u> , 19 <u>57</u> , and that death occurred at <u>2:5P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>William Newberry</u> M.D.			
PHYSICIAN'S NAME (Type) <u>William Newberry, M.D. Supt.</u>		<u>Mt. Wilson, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>3-27-57</u>	<u>NEW CATHEDRAL</u>	<u>BALTIMORE Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>George F. Schwalb 2101 Frederick Ave.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
		DATE <u>APR 26 1957</u>	<u>Dorothy Jewell</u>

BALTIMORE

MARYLAND

BALTIMORE

1111 CHURCH ST.

ANTHONY JOSEPH TIMING 3 54 21

MALE WHITE 1-31-86 11

T. R. RIVER BALTIMORE

FRANK TIMING THERESA (CHILD)

NO 10

PHYSICIAN

PHYSICIAN TUBERCULOSIS

ARTERIAL BLOOD PRESSURE 100/60

3-54 21 1-18 7-3-54 21

BUREAU V. S.

MAR 1937

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02691

## CERTIFICATE OF DEATH

02698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Milford</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Milford</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3702 Buckingham Road</b>				d. STREET ADDRESS <b>3702 Buckingham Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ROGER</b> Middle <b>SULLIVAN</b> Last <b>SULLIVAN</b>				4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 9, 1888</b>		9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Automobile Dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Sullivan</b>				14. MOTHER'S MAIDEN NAME <b>Mary Rodgers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-28-5968</b>		17. INFORMANT <b>Bertha V. Sullivan - 3702 Buckingham Road</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis of heart</b> DUE TO <b>Arteriosclerosis of heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis of heart</b> DUE TO <b>Arteriosclerosis of heart</b> (c) <b>Arteriosclerosis of heart</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3-18-57</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Pikesville</b>				20g. (County) <b>Maryland</b>		20h. (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>2-15-57</b> to <b>3-18-57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3-15-57</b> , and that death occurred at <b>2 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stanley Cohen</b> M.D.				ADDRESS (Street, city or town, state) <b>7306 Liberty Road, Baltimore 7, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Stanley Cohen</b>				DATE SIGNED <b>3-18-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/21/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ELLSWORTH ARMACOST-4600 Liberty Hgts. Ave.</b>				24a. REC'D BY REGISTRAR <b>APR 2 1957</b>			
24b. REGISTRAR'S SIGNATURE <b>Dr. Jm. E. Martin</b>							

RECEIVED

MAR 24 1957

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02692

## CERTIFICATE OF DEATH

02699

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b>				c. LENGTH OF STAY IN 1b <b>6 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>6927 Golden Ring Rd.</b>				e. STREET ADDRESS <b>6927 Golden Ring Rd.</b>			
3. NAME OF DECEASED (Type or print) <b>Lottie M. Sutton</b>				4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 29, 1890</b>		9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Conn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fred Orndner</b>				14. MOTHER'S MAIDEN NAME <b>Margaret McLaughlin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Harry G. Sutton</b> Address <b>6927 Golden Ring Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral haemorrhage</b> DUE TO <b>Cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatoid arthritis. Arteriosclerotic heart disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b> <b>7 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 28, 1948</b> to <b>Feb 23, 1957</b> , that I last saw the deceased alive on <b>Feb 23, 1957</b> , and that death occurred at <b>8 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H. L. Fuller MD</b> M.D.				ADDRESS (Street, city or town, state) <b>Rose Hill Road</b> DATE SIGNED <b>1957</b>			
PHYSICIAN'S NAME (Type) <b>H. L. FULLER MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/2/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Hill Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lassiter Funeral Home 7401 Belair Rd.</b>				24a. REC'D BY REGISTRAR <b>APR 2 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Edith Hurley</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 2 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02693

## CERTIFICATE OF DEATH

Reg. Dist. No.

02700

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>306 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>3023 CRESMONT AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOSHUA</b> Middle <b>W.</b> Last <b>TAIBOTT</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>17</b> Year <b>19 57</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT. 4, 1890</b>			
9. AGE (in years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRINTER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>NEWSPAPER</b>		11. BIRTHPLACE (State or foreign country) <b>CHESTERFIELD, MARYLAND</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>LAWRENCE TAIBOTT</b>				14. MOTHER'S MAIDEN NAME <b>ALICE COOKSEY</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		(If yes, give war or dates of service) <b>WW-1</b>		16. SOCIAL SECURITY NO. <b>216-03-1198</b>		17. INFORMANT <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE BASE OF THE TONGUE WITH MULTIPLE</b> <b>141 X</b> DUE TO <b>VISCERAL METASTASIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>BRONCHOPNEUMONIA BILATERAL</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <b>MAY 15, 19 56</b> , to <b>MARCH 17, 19 57</b> , that I last saw the deceased <b>alive on</b> <b>March 17, 19 57</b> and that death occurred at <b>3:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, Fort Howard, Maryland</b> DATE SIGNED <b>3-17-57</b> ACTUAL SIGNATURE: <b>Rolando D. Ponce de Leon</b> M.D. <b>VAH, Fort Howard, Maryland</b> PHYSICIAN'S NAME (Type) <b>ROLANDO D. PONCE DE LEON, M. D.</b> <b>VAH, Fort Howard, Maryland</b> <b>3-17-57</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-20-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND</b>		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>WILLIAM COOK-BLIGHT INC. FUNERAL HOME</b> <b>6009 HARFORD RD., BALTIMORE, MARYLAND</b>				24a. REC'D BY: REGISTRAR DATE <b>MARCH 18 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Lawson L. Farley</b>					

BUREAU V. S.

RECEIVED  
JAN 21 1900

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02549 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

027014  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>10</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Northshire</u>		c. LENGTH OF STAY IN 1b <u>appx 12 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Northshire</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7623 Cedar Rd</u>				d. STREET ADDRESS <u>7623 Cedar Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lawrence Vernon Taylor</u>				4. DATE OF DEATH Month Day Year <u>March 5 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 6-1892</u>		9. AGE (in years last birthday) <u>64 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto Transit</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Shava ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes.</u>		16. SOCIAL SECURITY NO. <u>213-05 9208</u>		17. INFORMANT Address <u>Mrs Rose Taylor 7623 Cedar Rd</u>			
18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Myocarditis (95-c-v Disen)</u> (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M.B. Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M.B. DAVIS M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran-3000</u>				ADDRESS <u>1. Baltimore Street</u>		24a. REC'D BY REGISTRAR <u>Mr. Kelly</u>	
				DATE <u>MAR 7 1957</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill page 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

1887



02694

## CERTIFICATE OF DEATH

02702

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b> d. STREET ADDRESS <b>Rt. 5, Dogwood Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LAFAYETTE</b> First Middle Last <b>THIESS</b>		4. DATE OF DEATH Month <b>Mar.</b> Day <b>19</b> Year <b>57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1892</b>
9. AGE (In years lost birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bricklayer (rtd)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Thiess</b>		14. MOTHER'S MAIDEN NAME <b>Matilda Rebel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Lafayette Thiess - Rt. 5, Dogwood Rd.</b> Address <b>Balto. 7, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Asthmatic bronchitis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>26 January, 1957</b> , to <b>18 March, 1957</b> , that I last saw the deceased alive on <b>18 March, 1957</b> , and that death occurred at <b>4: A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Millard T. Traband</b>		ADDRESS (Street, city or town, state) <b>5101 Gwynn Oak Ave. Balt. 7, 3/19/57</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Millard T. Traband, Jr. M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/22/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Randallstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tichenor &amp; Sons - Balt. 17 Md.</b>		24a. REC'D BY REGISTRAR <b>Dr. Wm. E. Martin</b> DATE <b>3/20/57</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 21 1957

BUREAU V. S.

02695

CERTIFICATE OF DEATH

02703 33

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>H.</b> Last <b>Thompson</b>		4. DATE OF DEATH Month <b>March</b> Day <b>28</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 9, 1879</b>
9. AGE (In years last birthday) yrs <b>77</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer self employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles H. Thompson</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Ann Meyers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>215-36-0064B</b>	
17. INFORMANT <b>Nona F. Thompson, Boring, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line (or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of prostate</b> <b>1971X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocarditis - chronic degenerative</b> DUE TO (c) <b> Cachexia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>1 yr</b> <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-1-55</b> 19 <b>3-28-57</b> , that I last saw the deceased alive on <b>3-26-57</b> , and that death occurred at <b>Reisterstown, Md.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James G. Saffell</b> M.D.		DATE SIGNED <b>Reisterstown, Md. 3-29-57</b>	
PHYSICIAN'S NAME (Type) <b>James G. Saffell</b>		ADDRESS <b>Reisterstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 31/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Piney Grove</b>	22d. LOCATION (City, town, or county) (State) <b>Boring, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>3-30-57</b>	
		24b. REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>	

BUREAU V. S.

APR 9 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

02696 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02704		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 45		
1. PLACE OF DEATH a. COUNTY <b>Baltimore (Zone 24) MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eastpoint (Essex)</b>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 311.4</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eastpoint Shopping Center</b>					d. STREET ADDRESS <b>853 N. Eutaw St.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>ELBERT First Middle Last Albert Jackson Tillman</b>					4. DATE OF DEATH <b>March 18, 19 57</b>		Month		Day		Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-27-1892</b>		9. AGE (In years last birthday) <b>64 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AL-EMAN</b>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Tai.</b>		12. CITIZENSHIP OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>ALBERT TILLMAN, Elbert Jackson</b>					14. MOTHER'S MAIDEN NAME <b>CALLIE CLARK</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>					16. SOCIAL SECURITY NO <b>NO</b>		17. INFORMANT <b>MARYALICE TILLMAN SAME</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY Occlus on</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>A-C-E-V-Disease</b> (c) DUE TO cause lost.										INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>							
20c. TIME OF INJURY Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .												
ACTUAL SIGNATURE <b>M. B. Davis</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3/18/57</b>					
EXAMINER'S NAME (Type) <b>M. B. Davis M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>3-21-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Peters</b>			22d. LOCATION (City, town, or county) (State) <b>Balt Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook Inc</b>					ADDRESS <b>1217 ST PAUL ST</b>		24a. REC'D BY REGISTRAR <b>3/20/57</b>		24b. REGISTRAR'S SIGNATURE <b>Edith Hunsley</b>			

13.2

1957

13.2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02550

CERTIFICATE OF DEATH

02705 41

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>11 Kinship Rd.</b>				d. STREET ADDRESS <b>11 Kinship Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>H.</b> Last <b>T odd</b>				4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 30, 1886</b>		9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Guard</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>George Todd</b>			14. MOTHER'S MAIDEN NAME <b>Lavina Foxwell</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-10-6411</b>		17. INFORMANT <b>Mrs. Viola Todd</b> Address <b>11 Kinship Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cirrhosis of Liver</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH <b>12 MIS-</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>A-S-C-V-D Disease</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from <b>March 9, 1956</b> to <b>March 10, 1957</b> , that I last saw the deceased alive on <b>March 9, 1957</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>M.B. Davis</b>			ADDRESS (Street, city or town, state) <b>6800 MORNINGSTAR RD. BALTIMORE, MD.</b>				
PHYSICIAN'S NAME (Type) <b>M.B. DAVIS MD</b>			DATE SIGNED <b>Dundalk - 22 - May 1957</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>Mar. 13, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home</b>				ADDRESS <b>Dundalk, Maryland</b>		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE <b>Tom M. Kelly</b>			

MAR 12 1957

RECEIVED

MAR 19 1957

BUREAU V. S.

1  
1. DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
2. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
02697 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02706  
44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fort Howard Hospital</b>		d. STREET ADDRESS <b>1003 Peach Street</b>	
3. NAME OF DECEASED (Type or print) <b>THOMAS TURNER</b>		4. DATE OF DEATH Month <b>March</b> Day <b>29</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-1-92</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <b>William Turner</b>		14. MOTHER'S MAIDEN NAME <b>Martha ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Ethel Turner, 1003 Peach Street</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Syphilitic Cardiovascular Disease</b> <b>023X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>023X</b> (a), stating the underlying cause last. (c) <b>023X</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Paul F. Guerin</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4/1/57</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/3/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Auburn</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore City</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Isaiah L. Brown</b>		ADDRESS <b>108 W Montgomery St</b>	
24a. REC'D BY REGISTRAR <b>4/3/57</b>		24b. REGISTRAR'S SIGNATURE <b>Lawson L. Lumberg</b>	

BUREAU V. 8

APR 4 1957

RECEIVED  
FBI

CERTIFICATE OF DEATH

02707

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House In The Pines Home</b>				d. STREET ADDRESS <b>1027 Riverside Ave. 16 Pasting Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>VAYNE,</b> Middle <b>Thomas</b> Last <b>E.</b>				4. DATE OF DEATH Month <b>March</b> Day <b>31,</b> Year <b>19 57</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 27, 1882</b>		9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Customs Insp.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Govt.</b>		11. BIRTHPLACE (State or foreign country) <b>Starr, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Vane</b>				14. MOTHER'S MAIDEN NAME <b>Laura Virginia Lane</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT Address <b>Mr. Charles Vayne 1323 Silver Thorne Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency &amp; Failure</b> <b>4. 4.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Extensive Coronary Artery Disease</b> DUE TO (c) <b>5 years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>3/25/57</b>	
20f. (City or town) <b>Centreville, Md.</b>				20g. (County) (State)			
21. I certify that I attended the deceased from <b>1/15</b> , 19 <b>57</b> , to <b>3/25</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3/25</b> , 19 <b>57</b> , and that death occurred at <b>3/25/57</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>107 E. West St.</b> DATE SIGNED <b>4/1/57</b>							
ACTUAL PHYSICIAN'S NAME (Type) <b>E. S. ELLISON</b>				M.D. <b>107 E. West St.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/2/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Chesterfield Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Centreville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. DENNY, INC. 715 Light St. -30</b>				24a. REC'D BY REGISTRAR <b>DATE APR 2 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Overman</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02563 CERTIFICATE OF DEATH

02708

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) STATE <u>MD</u> COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus 27</u>		c. LENGTH OF STAY IN 1b <u>lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1621 Shepherd Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Max</u> Last <u>Hall</u>				5. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1957</u>			
4. SEX <u>Female</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug-6 1909</u>	
9. AGE (In years last birthday) <u>47 yrs.</u>		10. UNDER 1 YEAR Months <u>4</u> Days <u>10</u> Hours <u>15</u> Min <u>00</u>		11. UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>00</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Robert W. Daily</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>1-100-100000</u>			
17. INFORMANT <u>Robert W. Daily</u>				Address <u>1621 Shepherd Drive</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic C.V.D.</u> <u>410X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Stenosis</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. n.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/1</u> , 1957, to <u>3/25</u> , 1957, that I last saw the deceased alive on <u>3/23</u> , 1957, and that death occurred at <u>3:45</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John C. Healy</u> M.D.				ADDRESS (Street, city or town, state) <u>1441 Bayview Rd</u> DATE SIGNED <u>3/27/57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Mar 28 57</u>		<u>Greenwood</u>		<u>Baltimore</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert W. Daily</u> ADDRESS <u>1621 Shepherd Drive</u>				24a. REC'D BY REGISTRAR <u>RR 1</u> DATE <u>3/27/57</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Geo M. Kuffner</u>	

MEDICAL CERTIFICATION

BUREAU V. S.

APR -

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02709

02699

CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>			
c. LENGTH OF STAY IN 1b <u>36 yrs</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>223 Church Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Eugene</u> Last <u>Walter</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 12, 1887</u>	9. AGE (In years last birthday) <u>69</u> yrs	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS Hours _____ Min. _____	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager Bureau Engraving</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager Bureau Engraving</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>US Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Harry Jackson Walter</u>			
14. MOTHER'S MAIDEN NAME <u>Emma Caroline Pepler</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT Address <u>Mrs HE Walter 223 Church Lane Pikesville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral vascular accident, lt. hemiplegia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from _____, 1953, to _____, 1957, that I last saw the deceased alive on _____, 1957, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul H Royse</u>				ADDRESS (Street, city or town, state) <u>408 Reisterstown Rd</u>			
M.D. <u>Pikesville 8 Md</u>				DATE SIGNED <u>MAR 18 1957</u>			
PHYSICIAN'S NAME (Type) <u>Paul H Royse</u>				FURNAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>March 16, 1957</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Wood Ridge Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Pikesville 8 Md</u>			
23. FURNAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>				24. REC'D BY REGISTRAR <u>Dorothy Newell</u>			
24a. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>				24b. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>			

BUREAU V. S.

MAR 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02700 CERTIFICATE OF DEATH

02710

Reg. Dist. No. 37

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LUTHERVILLE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LUTHERVILLE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1508 GREENSPRING DRIVE</b>				d. STREET ADDRESS <b>1508 GREENSPRING DR</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNA WATCHMAN</b>				4. DATE OF DEATH Month Day Year <b>MARCH 16 1957</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 30, 1873</b>	
9. AGE (In years last birthday) <b>84 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN RENNER</b>				14. MOTHER'S MAIDEN NAME <b>MOLLY HOLDEFER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>218-26-0008B</b>			
17. INFORMANT <b>HENRY H. WATCHMAN-SR</b>				Address <b>LUTHERVILLE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio-Vascular Disease</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>December 1956</b> to <b>March 16<sup>th</sup>, 1957</b> that I last saw the deceased alive on <b>March 16<sup>th</sup>, 1957</b> , and that death occurred at <b>2 PM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <b>M. X. Quinn</b> M.D. <b>1927 York Rd. TIMONIUM, Md. 3/18/57</b>							
PHYSICIAN'S NAME (Type) <b>M. KEVIN QUINN MD</b>				<b>TIMONIUM Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>MAR-19-1957</b>		<b>BALTIMORE</b>		<b>BALTIMORE MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM. COOK-TOWSON-INC</b>				ADDRESS <b>1050 YORK RD.</b>			
24a. REC'D BY REGISTRAR DATE <b>3/19/57</b>		24b. REGISTRAR'S SIGNATURE <b>H. St. Hedrick</b>					

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BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G212 3-14-57 et

## CERTIFICATE OF DEATH

02711

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <b>md</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto Co md</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>317 Della Avenue</b>		d. STREET ADDRESS <b>319 Della ave</b>	
3. NAME OF DECEASED (Type or print) <b>Olivia Jane Webb</b>		4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>1957</b>	
5. SEX <b>7</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 25, 1871</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>md</b>	
11. BIRTHPLACE (State or foreign country) <b>md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A</b>	
13. FATHER'S NAME <b>---</b>		14. MOTHER'S MAIDEN NAME <b>---</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Luther Webb</b>		Address <b>319 Della ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mitral Insufficiency</b> <b>422.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic Heart Disease</b> DUE TO (c) <b>---</b>			INTERVAL BETWEEN ONSET AND DEATH <b>127 Day</b> <b>2</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10-2-56</b> , 19____, to <b>3-6-57</b> , 19____, that I last saw the deceased alive on <b>3-6-57</b> , 19____, and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C.F. Maloney - M.D.</b>		M.D. <b>57 Winters Lane, Catonsville</b> <b>3/7/57</b>	
PHYSICIAN'S NAME (Type) <b>C.F. Maloney, M.D.</b>		Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-9-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Western Star</b>	22d. LOCATION (City, town, or county) (State) <b>Catonsville md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mr. B. Nelson</b>		ADDRESS <b>1348 N. Calhoun St</b>	
24a. REC'D BY REGISTRAR DATE <b>3/8/57</b>		24b. REGISTRAR'S SIGNATURE <b>A. H. Hedrick</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02702 CERTIFICATE OF DEATH

02712

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 3 Vol. 4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>College Manor Nursing Home</b>		d. STREET ADDRESS <b>101 W. Monument St.</b> <input type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CLARA ASHLEY WEECH</b>		4. DATE OF DEATH <b>March 30, 1957</b> 19 <b>19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 5, 1869</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR: Months <b>2</b> Days <b>4</b> Hours <b>22</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Alexander McClure Ashley</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Cox</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b> (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <b>Mr. C. Sewell Weech</b> Address <b>4000 N. Charles St.</b>	
17. INFORMANT <b>Mr. C. Sewell Weech</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>distal aortic C.V. disease</b> <b>442X</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour <b>a. m.</b> p. m.		20d. INJURY OCCURRED <b>White</b> <input type="checkbox"/> <b>Not white</b> <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1948</b> , 19____, to <b>3/30/57</b> , 19____, that I last saw the deceased alive on <b>3/30/57</b> , 19____, and that death occurred at <b>7:45 P.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>100 W. University Pkwy Baltimore, Md</b> DATE SIGNED <b>4/1/57</b> ACTUAL SIGNATURE <b>Francis W. Gluck</b> M.D. <b>Francis W. Gluck</b> PHYSICIAN'S NAME (Type) <b>Francis W. Gluck</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 1, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons</b> ADDRESS <b>1900 Eutaw Place</b>		24a. REC'D BY REGISTRAR <b>APR 2 57</b> 24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>	

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02713

## 02703 CERTIFICATE OF DEATH

Reg. Dist. No 44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>28 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALONZO</b> Middle <b>WILLIAMS</b> Last				4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>October 4, 1908</b>	9. AGE (In years last birthday) <b>48</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Catering Company</b>		11. BIRTHPLACE (State or foreign country) <b>Dunn, North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>French G. Williams</b>				14. MOTHER'S MAIDEN NAME <b>Hernie Hartfield</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II 216-03-8886</b>		17. INFORMANT Address <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF STOMACH, MULTIPLE VISCERAL METASTASIS</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>February 27, 1957</b> , to <b>March 27, 1957</b> , and that death occurred at <b>9:00 P. M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Rolando D. Ponce de Leon</b>				ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>		DATE SIGNED <b>2/28/57</b>	
PHYSICIAN'S NAME (Type) <b>ROLANDO D. PONCE de LEON, MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-30-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE <b>3/30/57</b>		24b. REGISTRAR'S SIGNATURE <b>Lawson L. Fisher</b>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02704 CERTIFICATE OF DEATH

02714

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. LENGTH OF STAY IN 1b <b>Parkville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3008 Linwood Ave.</b>		d. STREET ADDRESS <b>3006 Linwood Ave.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elizabeth F. Williamson</b>		4. DATE OF DEATH Month Day Year <b>March 12, 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 28, 1912</b>
9. AGE (In years last birthday) <b>44</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Samuel Burnham</b>		14. MOTHER'S MAIDEN NAME <b>Mary Sullivan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-20-9244</b>	
17. INFORMANT <b>Mrs. Mary McNeave</b>		Address <b>8632 Black Oak Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>12 Day</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3/12/57</b> , 19____, to _____, 19____, that I last saw the deceased alive on <b>3/12/57</b> , 19____, and that death occurred at <b>3:27 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8100 Harford Rd.</b> DATE SIGNED <b>3/13/57</b>			
ACTUAL SIGNATURE <b>H. A. Grott</b>		M.D. <b>8100 Harford Rd.</b>	
PHYSICIAN'S NAME (Type) <b>H. A. Grott</b>		<b>8100 Harford Rd.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 15, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Balto. U. S. National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louisa Funeral Home</b>		ADDRESS <b>9401 Belair Rd.</b>	
24a. REC'D BY REGISTRAR <b>Dr. A. M. Bacon</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. A. M. Bacon</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate is for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02705

## CERTIFICATE OF DEATH

Reg. Dist. No.

02715

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>4 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>511 Forrest Lane</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>511 Forrest Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Ella Blanche Willis</b> First Middle Last				4. DATE OF DEATH <b>March 14 1957</b> Month Day Year			
5 SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 18, 1877</b> 9. AGE (In years last birthday) <b>80</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John W. Mills</b>				14. MOTHER'S MAIDEN NAME <b>Catherine (Unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>222-18-4230</b>		17. INFORMANT <b>William N. Willis, Jr.</b> <b>511 Forrest Lane.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with Carcinomatosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1953</b> to <b>3/14</b> , 1957, that I last saw the deceased alive on <b>3-4</b> , 1957, and that death occurred on <b>12 noon</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Martin L. Singewald</b> M.D.				DATE SIGNED <b>3/15/57</b>			
PHYSICIAN'S NAME (Type) <b>MARTIN L. SINGEWALD MD</b>				ADDRESS (Street, city or town, state)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/16/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Amberse Inc. 1328 Sulphur Spring Rd.</b>				24a. REC'D BY REGISTRAR <b>MAR 18 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Paul Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02706

## CERTIFICATE OF DEATH

02716

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>34 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle Last <b>WILMER</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>3</b> Year <b>19 57</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-8-1903</b>	9. AGE (In years last birthday) <b>53</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ROOFER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>ROOFING</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>WILLIAM HENRY WILMER</b>				14. MOTHER'S MAIDEN NAME <b>AGNES ABRAMS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>WW-11</b>		17. INFORMANT Address <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EDEMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HYPERTENSIVE DISEASE</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>January 28</b> , 19 <b>57</b> , to <b>March 3</b> , 19 <b>57</b> and that death occurred at <b>1:25 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Rolando D Ponce de Leon</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>3/4/57</b>			
PHYSICIAN'S NAME (Type) <b>ROLANDO D. PONCE de LEON, M.D.</b>				M.D. <b>VETERANS ADMINISTRATION HOSPITAL</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/6/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law Mortuary, 802-04 Madison Ave., Baltimore, Md.</b>				24a. REC'D BY REGISTRAR <b>3/6/57</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Farley</b>	

BUREAU V. S.

NO. 2 11 7

RECEIVED

02707

## CERTIFICATE OF DEATH

02717

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. COUNTY <b>Maryland</b> <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>120 Slade Avenue</b>				d. STREET ADDRESS <b>120 Slade Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Victor</b> Middle <b>Windesheim</b> Last <b>Windesheim</b>				4. DATE OF DEATH Mar. 19th 1957			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 1" 1878</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dry Goods</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Windesheim</b>				14. MOTHER'S MAIDEN NAME <b>Julia ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>E.W. Lamoreau, 4510 Liberty Heights Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>Art. Sclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 m 14 s</b> <b>2 yrs.</b> <b>2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Jan. 1950</b> to <b>March 19th 1957</b> , that I last saw the deceased alive on <b>March 27th 1957</b> , and that death occurred at <b>7 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Pikesville, Md. &amp; Walker Ave.</b> DATE SIGNED <b>3/21/57</b>							
ACTUAL SIGNATURE <b>James A. Miller</b>				M.D. <b>Reisterstown, Rd. &amp; Walker Ave.</b>			
PHYSICIAN'S NAME (Type) <b>James A. Miller</b>				<b>Pikesville, Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 22" 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Balto. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E.W. Lamoreau</b>				24. REC'D. BY REGISTRAR <b>25 1957</b>			
				24b. REGISTRAR'S SIGNATURE <b>Samuel Newell</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
U. S. A.

1961

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02708

## CERTIFICATE OF DEATH

02718 44  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3401.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>257 South East Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>O.</b> Last <b>WISE</b>		4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 11, 1877</b> 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Silversmith</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Silver Company</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Wise</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Goellers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes</b> <b>SAW</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA LOBAR BILATERAL</b> 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>11 DAYS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4200 <b>ARTERIOSCLEROTIC HEART DISEASE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 4</b> , 1957, to <b>March 13</b> , 1957, and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Abraham A. Polachek</b> M.D. V.A.H., FORT HOWARD, MARYLAND <b>3/13/57</b> PHYSICIAN'S NAME (Type) <b>ABRAHAM A. POLACHEK</b> M.D. V.A.H., FORT HOWARD, MARYLAND <b>3/13/57</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-18-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>
22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		24a. REC'D BY REGISTRAR <b>18 1957</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Vm. Cook-Blight, Inc., 6009 Harford Rd. Baltimore Md.</b>		24b. REGISTRAR'S SIGNATURE <b>L. G. L. G.</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. S.

MAR 19 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02709

## CERTIFICATE OF DEATH

02719

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 3V01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor Nursing Home</b>		d. STREET ADDRESS <b>1964 N. Patterson Park Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Wyczalek</b> Last		4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 2, 1882</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Poland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph Kwarcina</b>	
14. MOTHER'S MAIDEN NAME <b>Julia</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Joseph Wyczalek</b> Address <b>5602 Fair Oaks Avenue</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO (b) <b>Generalized Substitution</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma Generalized</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>6 months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb. 29, 1957</b> to <b>March 30, 1957</b> , that I last saw the deceased alive on <b>March 29, 1957</b> , and that death occurred at <b>6:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>6014 ERMANDSON AVE. Balt 28 Md 4/1/57</b>			
ACTUAL SIGNATURE <b>J. Nelson McKay</b>		PHYSICIAN'S NAME (Type) <b>J. Nelson McKay</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>April 3, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lilly &amp; Zeiler Inc., 403 S. Wolfe St.</b>		24a. REC'D BY REGISTRAR <b>APR 1 57</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>			

MARYLAND STATE DEPT. OF PUBLIC SAFETY—BALTIMORE, MD.

APR 2 1957

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